DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2010-11 JOINT BUDGET COMMITTEE HEARING AGENDA

Monday, December 21, 2009
10:00 am – 5:00 pm

HEALTH CARE POLICY AND FINANCING

10:00-10:20 INTRODUCTIONS AND OPENING COMMENTS

10:20-11:50 IMPACT OF BUDGET REDUCTIONS TO THE MEDICAID PROGRAM

Overview of Provider Rate Reductions

1. **Please describe the provider rate reductions that the Department has implemented since July 1, 2009 and the new provider rate reductions proposed for FY 2010-11.**

   RESPONSE:

   The Department has implemented several varieties of provider rate/expenditure reductions since the beginning of the fiscal year including targeted rate reductions, strategies for limiting utilization and volume, administrative pricing and billing modifications, and across-the-board rate reductions when necessary.

   During FY 2008-09, it became evident that reductions would be required in FY 2009-10 in order to close the widening state budget gap. Effective July 1, 2009, a two percent (2%) across-the-board reduction in provider rates was determined necessary. In an effort to avoid this measure, months prior to the proposed implementation, the Department began an unprecedented outreach effort to solicit recommendations from providers, clients, advocates, and other stakeholders for targeted initiatives to reduce unnecessary utilization, control volume, increase efficiency, and promote cost-effective practices to offset direct provider rate reductions. The Department was thus able to avoid cuts for primary care, personal care and dental care services. While other services did receive the 2% proposed rate reduction, the Department was able to implement many of the recommendations received through this collaborative communication process.

   Dental providers avoided the across-the-board reduction in July by supporting policy and pricing changes such as reimbursing resin-based composite fillings and amalgam fillings at equivalent rates; disallowing medically unnecessary prophylactic extraction of third molars (wisdom teeth); and allowing dental procedures that otherwise would be performed in the outpatient hospital setting to be covered when performed in Ambulatory Surgery Centers. Likewise, Durable Medical Equipment providers were able to offset a small percent of their rate reduction in July by supporting policy and pricing changes such as volume limitations on the provision of urological supplies; setting a maximum price for manually priced wheelchair

tilt procedure codes; and changing the reimbursement and/or volume limits on a number of wheelchair repair codes to eliminate or modify prior authorization requirements.

The Department was able to exempt preventive health visit codes and evaluation and management codes (office visits) from the reduction in July, as well as rates for Home Health certified nurse's aides, personal care services, and homemaker services provided through Home and Community-Based Services waivers.

Additional budget shortfall estimates required additional reductions to HCPF's budget during the fiscal year. A one-and-a-half percent (1.5%) across-the-board rate reduction for all physical health services and a two-and-a-half percent (2.5%) reduction of Behavioral Health Organizations capitations was required effective September 1st. Of note, the BHOs did not have a July 1, 2009 cut. A further one percent (1%) across-the-board reduction was implemented December 1st in order to meet budget reduction targets. Encounter reimbursement rates paid to Federally Qualified Health Centers were reduced as were pharmacy reimbursement rates and managed care organization capitation rates.

The Department considers rate cuts to be actions of last resort and sought to find other efficiencies to prioritize higher. Other expenditure reduction initiatives implemented since July that helped to avoid rate reductions of greater magnitude included eliminating payment for services resulting from Serious Reportable Events (Never-Events) in hospitals or readmissions within 24 hours of discharge; implementing prior authorization requirements for non-emergency computed-tomography scans, magnetic resonance imaging scans, and positron emission tomography scans; placing limits on non-medical transportation provided through Home and Community-Based Services; expanding the number of therapeutic drug classes covered by the Preferred Drug List; reducing the number of benefits that require manual pricing of each individual claim by assigning fee schedule rates for more efficient, automated processing; realigning pricing for codes previously reimbursed at rates above Medicare; suspending some supplemental payments to certain types of hospitals; and modifying provider payment timing for a short period at the end of the fiscal year.

The provider rate reductions proposed for July 1, 2010, FY 2010-11 include a one percent (1%) rate reduction for most Medicaid services including basic acute care and preventive services, Long Term Care and Home and Community-Based Services, nursing facilities, Program of All Inclusive Care for the Elderly, and Single Entry Point agencies, and corresponding reimbursement rate reductions for managed care organization capitations. The Department is not proposing additional cuts to pharmacy. Additionally, a two percent (2%) reduction to Behavioral Health Organization capitation rates is proposed. This action would take the BHOs to 4.5% below the actuarial mid-point and 0.5% above the bottom of the actuarially certified range. Other expenditure reductions would be realized from proposed limitations on incontinence products and oral nutrition, as well as through billing efficiencies and modifications such as implementing alternative unit increments for billing Home Health services, delaying payments from the MMIS by four weeks in June 2011, and adjusting the reimbursement rates of mid-level practitioners to 90% of physician rates for comparable

services. Modifying the physician and hospital drug rebates as well as limiting the nursing facility General Fund maximum growth to zero percent (0%) have also been proposed. Gross expenditure reductions are also anticipated as a result of shifting to the Accountable Care Collaborative model.

In total, the Department's proposed reductions are estimated to permanently reduce expenditure (by FY 2011-12) by $245 million total funds, $119 million General Fund per year. Over the 3-year period of FY 2009-10 through FY 2011-12, this is a $652 million total funds, $320 million General Fund reduction. This does not account for one-time financing savings, such as delaying Medicaid payments. Overall, this reduction is approximately 3 times the amount of the reductions in FY 2002-03 and FY 2003-04.

2. **What requirements, if any, do federal law or guidelines require to ensure provider rates are adequate or meet the cost of providing the service? Do the recent provider rate reductions risk Colorado being out of compliance with federal law?**

RESPONSE:

Federal Requirements

The ceiling and floor on payments to providers is derived from the so-called "equal access provision" contained in federal statute:

Under 42 USC 1396(a)(30)(A) State Plan Requirements "A State plan for medical assistance must—(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b (i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services *and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area*;"

Basically, this statute requires that payments for medical services be no more than the cost necessary to be efficient and economical, and no less than the cost necessary to provide access to the same quality of services enjoyed by private health care plans and Medicare subscribers.

There are a handful of federal court decisions providing guidance on the application of the equal access provision to specific rate cut actions by the states. Some of these court cases have been brought by providers claiming they are not achieving sufficient reimbursement under law; others have been brought by recipients in the Medicaid program claiming that rate cuts have driven providers out of a medical specialty depriving them of care. Courts have been inconsistent in their interpretation of the equal access provision and the divergence is significant enough that rate cuts deemed unacceptable in one jurisdiction pass muster in another. There are no decisions interpreting the equal access provision from the U.S. circuit court with jurisdiction over Colorado.

Risk of Reductions on Federal Compliance

The Department began an unprecedented, widespread provider/stakeholder communication initiative months prior to the July 1st reductions. The Department actively engaged a wide variety of providers, provider organizations and client advocacy groups to communicate the Department's fiscal limitations and legislative mandate to reduce expenditures. In an effort to avoid across-the-board rate reductions, the Department sought and was granted authority by the General Assembly to work with providers and stakeholders. As a part of this effort, the Department proposed and implemented alternative cost-savings measures such as utilization/volume containment strategies and efficiency improvements that would generate the savings needed to avoid the rate reductions. Rate reductions for some service categories were lessened or completely offset by implementation of those cost-savings suggestions as feasible and appropriate. In those areas where no practical alternatives to the rate reduction were identified, the reductions were applied. In a limited number of areas, providers recommended that the Department implement the across-the-board cuts for their services rather than identify service reductions. Throughout this process, provider organizations and advocacy groups expressed their gratitude for their inclusion in the decision-making process and the collaborative approach taken by the Department. The Colorado Medical Society, specifically, worked closely with the Department throughout this process and expressed its commitment to continue to work with Medicaid in the future. In the last several years prior to the recession, the Department was able to increase rates for many of the most-utilized services including evaluation and management services as well as surgery and dental. In most cases, even when taking into account the recent series of reductions, services are priced higher than they were in FY 2003-04, the turning point for the last recession. The rate reductions implemented this fiscal year bring rates to levels that have, in the past, been adequate in maintaining provider enrollment and client access.

The Centers for Medicare and Medicaid Services (CMS) asked several questions regarding the regulations found at 42 CFR §447.204 requiring adequate payments for services when the state plan amendments (SPAs) to implement the rate reductions were submitted for approval. The following rate reduction SPAs have been approved by CMS: Home Health & Private Duty Nursing, Physician Services, Non-physician Practitioner Services, Clinic Services, Prosthetics, Laboratory and Radiology Services and Federally Qualified Health Clinics. No SPAs have been disapproved nor have any changes been requested by CMS to address concerns about client access to care.

Within the context of the discussion above, the Department believes that the risk of a successful legal challenge to Medicaid provider rate reductions is manageable at this point.

3. **Has the Department had any indications that providers will leave the Medicaid program because of lower reimbursement rates?**

RESPONSE:

Over the course of this fiscal year, the Department actively engaged a wide variety of providers, provider organizations and client advocacy groups to communicate the Department's fiscal limitations and legislative mandate to reduce expenditures. Throughout this process, provider organizations and advocacy groups expressed their gratitude for their inclusion in the decision-making process and the collaborative approach taken by the Department in soliciting and developing innovative alternatives to provider rate reductions. The Colorado Medical Society, specifically, worked closely with the Department throughout this process and expressed its commitment to continue to work with Medicaid in the future.

The Department believes that utilizing this collaborative approach in working with the Medicaid providers has strengthened its mutual commitment to serving the publically insured population and Colorado's most vulnerable residents. Some providers expressed their frustration and disappointment regarding rate reductions and the Department's inability to take all suggestions (some had delayed payback timing and many suggestions were, in effect, to take from another provider type which elicited strong reactions from that target provider). However, the responses and communications from the majority of the provider community that participated in discussions and interactions indicated that they understood the unfortunate economic circumstances facing the state and the limited options available to the Department.

Using data from the Medicaid Management Information System, the Department has analyzed trends in provider enrollment and participation over the past year and has seen a net increase in the number of enrolled providers from 30,419 as of November 2008 to 32,670 as of November 2009. The Department has in fact seen an increase in the average number of providers enrolling per month since the beginning of the state fiscal year, and a decrease in the average number of providers terminating participation each month. Between January and June 2009, the Department enrolled an average of 249 providers per month, and an average of 30 providers terminated participation each month. Between July and November 2009, enrollment increased to an average of 337 providers per month and terminations decreased to an average of 21 per month.

Specifically with regard to physicians and dentists, the Department has seen an increase in enrollment since the initial rate reductions in July. Between January and June 2009, the Department enrolled an average of 81 physicians and 12 dentists per month while an average of three physicians and less than one dentist terminated participation per month. Since July 2009, enrollment has increased to an average of 123 physicians and 19 dentists per month while average terminations has dropped to less than one per month for each of these provider types. With regard to home health agencies, just prior to the reductions in July 2009, the Department had 166 enrolled home health agencies. As of the end of November 2009, the Department has 167 enrolled home health agencies. Likewise, the number of providers of

Home and Community-Based Services has also increased from 1,175 enrolled providers at the end of June 2009 to 1,242 as of November 2009. Please see Attachment Q3 for provider enrollment trends since FY 2000-01.

As indicated by the figures above, the Department has not seen any negative impact on provider enrollment and participation in general, and finds no evidence that access to care was inhibited in prior years where rate reductions were of a greater magnitude than the decreases applied to most services this fiscal year. Therefore, the Department does not anticipate that providers will terminate participation with Medicaid in above-average numbers, nor does it believe that client access to care will be at risk due to these reductions.

4. **Please provide a graphic view of provider rates since FY 2000-01. If possible can the Department also provide information comparing the Department's provider reimbursement rates to other state Medicaid rates and compared to inflation adjustments (from FY 2000-01 base year).**

   RESPONSE:

   Please see graphs in Attachment Q4.

Pharmacy Rates

5. **Please describe the policy reasons for the reductions made to pharmacy since FY 2001-02 {include both utilization controls and reimbursement reductions}.**

   RESPONSE:

   Pharmacy Reimbursement

   Approximately 93% of in-state pharmacies currently contract with Colorado Medicaid. Data queried December 17, 2009 show 872 in-state pharmacies are enrolled as Medicaid providers out of 944 reported by the Colorado Board of Pharmacy as licensed in-state prescription drug outlets. The Department has reduced reimbursement rates to pharmacies several times since FY 2001-02 as a result of budget balancing activities. However, despite rate reductions, reimbursement to pharmacies continues to rise, as rates paid for most drugs are based on a commercial benchmark that is self-reported by manufacturers and increases substantially over time.

   Medicaid's reimbursement to pharmacies is based on the pharmacy's retail price for a drug or the Medicaid-allowed drug cost, whichever is less, plus a dispensing fee and co-pay. The Medicaid-allowed drug cost is determined by reviewing several pricing methodologies and selecting whichever methodology results in the lowest reimbursement.

   Those pricing methodologies include:
   - Average Wholesale Price minus a fixed percentage;
   - Direct Price plus a percentage;

- State Maximum Allowable Cost; or,
- Federal Upper Limit.

In practice, about 87% of pharmacy claims, on a dollar basis, are reimbursed using Average Wholesale Price minus a fixed percentage.

Average Wholesale Price (AWP)
Average Wholesale Price is a pricing benchmark printed in commercial publications; however, it is not defined in law or regulation and has no basis on actual sales or pricing data. Average Wholesale Price is based on data self-reported by drug manufacturers to the commercial publications. Most states use Average Wholesale Price as one of their benchmarks to determine pharmacy reimbursement. The dominant use of Average Wholesale Price has largely resulted from the lack of a more accurate benchmark available to the states.

Reimbursement Rates
One of the policy goals when setting pharmacy reimbursement rates is to manage the expenditures for pharmacy benefits in a fiscally responsible manner. A review of pharmacy rates since FY 2000-01 found that rates were reduced in FY 2001-02 and FY 2002-03 as budget balancing actions. The rates were then increased in FY 2002-03 to AWP-13.5% for brand name drugs, AWP-35% for generics and AWP-12% for rural pharmacies. Those rates remained in effect until the most recent rate reductions effective July 1, 2009 and September 1, 2009; however, the rural pharmacy rate has not been reduced. The current rates are AWP-14.5% for brand drugs and AWP-45% for generics.

The Department has not, however, made any request to increase pharmacy rates during that time period, because the Average Wholesale Prices for individual drugs has, for most agents, grown rapidly over the past seven years. In fact, a Department survey of the Average Wholesale Prices for 10 highly utilized drugs found, on average, the growth in Average Wholesale Price was 56% over the last 7 years. So even though the Department's reimbursement rates did not change during that period, the actual reimbursement to pharmacies increased because the Average Wholesale Prices increased. Given the steady growth in actual reimbursement, in conjunction with the imperative to reduce expenditures in this fiscal year, the recent pharmacy reductions were appropriate. Comparisons with other states show that about one-third of states have set even larger reductions off of Average Wholesale Price for brand drugs.

<u>Drug Utilization Controls</u>
Drug utilization controls have been historically implemented for three policy reasons:
- To promote the clinically appropriate and safe utilization of drugs;
- To promote the utilization of more cost-effective medications when clinically appropriate; and
- To assure that Medicaid only reimburses for drugs for which federal matching funds are available.

A number of utilization controls are found in statute. For example, section 25.5-5-501(2), C.R.S. (2009) requires that the Department pay for less-costly generic drugs, where they exist; section 25.5-5-506, C.R.S. (2009) requires the Department to implement utilization controls, and; section 25.5-5-507, C.R.S. (2009) established the prescription drug information and technical assistance program. In addition, Executive Order D 004 07 established a preferred drug list, which allows the Department to decrease expenditures by selecting a preferred agent and obtain supplemental rebates from manufacturers.

The Department has also established a Drug Utilization Review (DUR) Board to review drug utilization issues and make recommendations to the Department to optimize appropriate prescription drug use. The DUR Board findings are used by the Department to review identified drugs and to achieve expenditure reduction in pharmaceuticals.

Some examples of utilization controls include:

- Imposing dosing limits for drugs for safety reasons;
- Implementing prior authorizations on specific drugs and drug classes to assure utilization is clinically appropriate, consistent with Food and Drug Administration-approved indications and/or to promote utilization of more cost-effective medications;
- Implementing prior authorizations and system edits to assure that Medicaid only reimburses for drugs for which the Department can receive federal matching funds;
- Selecting Preferred Products for drug classes on the Preferred Drug List to increase utilization of more cost-effective alternatives where safety and effectiveness are equivalent;
- Allowing licensed pharmacists to consult with clients to prevent dangerous drug interactions, improve patient outcomes, and;
- The review of client drug histories by the Drug Utilization Review Board in order to optimize clients' drug therapy regimens, promote good health outcomes, and educate prescribers.

6. **Please describe the impact that the First Databank settlement has on pharmacy rates. How have other health plans adjusted reimbursement to pharmacy due to the First Databank settlement? Does the Department's rate reductions, as well as the impact of the First Databank settlement, disproportionately reduce pharmacy reimbursement when compared to other provider rate reductions?**

   RESPONSE:

   Effective September 26, 2009, the Average Wholesale Price (AWP) for a large number of drugs was decreased by the publisher of AWP (First DataBank) as a result of a settlement in a class action lawsuit which alleged that the AWP was artificially inflated. Because the majority of Medicaid pharmacy reimbursement is based on the AWP (as described in the Department's response to question 5), the reduction to AWP is generating a reduction to the Department's Medical Services Premiums expenditure.

Impact of First Databank settlement on Pharmacy Reimbursement

The replacement Average Wholesale Prices published pursuant to the First DataBank settlement are expected to reduce pharmacy expenditures by approximately $5.1 million in FY 2009-10, annualizing to $6.8 million in FY 2010-11. This reduction represents an annualized reduction of approximately 2.5%. The Department has included this reduction in DI-1, "Request for Medical Services Premiums," FY 2010-11 Budget Request, Exhibit F, November 6, 2009.

Reaction by Other States

Most states are not changing Medicaid reimbursement rates as a result of the First DataBank settlement. In fact, a survey conducted in September by the National Association of State Medicaid Directors found that 48 states were not adjusting rates.

Private Payers

Early reports indicate that the impact to private payer health plans depends on the terms of their contracts with Pharmacy Benefit Managers. Some private payers are currently adjusting their reimbursement to pharmacies to make them whole, pursuant to their contracts. Other payers will be revisiting this issue during future contract negotiations.

Pharmacy Rate Reductions Compared to Other Rate Reductions

The estimated reduction to pharmacy expenditure in FY 2009-10 due to rate reductions is similar to the reductions which have been imposed on dental providers, durable medical equipment providers, federally qualified health care centers, and hospitals. Approximately half of the estimated reduction to pharmacy expenditure, approximately $5.1 million total funds, is due to the First DataBank lawsuit and settlement. If not for the First DataBank settlement, the Department estimates that the reductions to pharmacy reimbursement implemented in July and September 2009 would have reduced FY 2009-10 expenditure by $7.5 million total funds, or approximately 2.9%.

The chart below shows the estimated decrease in expenditure as a result of budget actions which directly reduced provider reimbursement.[1] The chart reflects Medical Services Premiums (Medicaid) expenditure only.

Service Category	FY 2009-10 Estimated Expenditure[(a)]	FY 2009-10 Estimated Reduction[(b)]	Estimated Percentage Reduction to Expenditure
Dental	$88,283,123	($4,190,601)	-4.75%
Durable Medical Equipment	$88,924,425	($3,389,220)	-3.81%
Federally Qualified Health Centers	$84,394,823	($3,915,491)	-4.64%
Home and Community-Based Services (HCBS)	$243,455,852	($8,445,936)	-3.47%
Home Health	$170,117,662	($4,826,932)	-2.84%
Hospitals	$589,441,985	($25,444,228)	-4.32%
Nursing Facilities	$537,747,144	($6,411,926)	-1.19%
Pharmacy	$269,811,094	($12,884,762)	-4.78%
Practitioner Services	$302,146,480	($17,510,740)	-5.80%
Other	$528,748,670	($6,104,706)	-1.15%

(a) FY 2009-10 estimated expenditure is based on information the Department provided in DI-1, "Request for Medical Services Premiums,' FY 2010-11 Budget Request, November 6, 2009; the amounts presented are based on forecasted totals before rate reductions have been taken into account, to prevent double-counting. Further, because the Department does not forecast by service category in all cases, where necessary FY 2008-09 cash flow has been applied to the FY 2009-10 to give rough estimates by service category.

(b) The FY 2009-10 estimated reduction accounts for only those initiatives the Department has implemented which directly affects reimbursement (such as rate reductions). Utilization controls, such as increased prior authorizations, or expansion of a preferred drug list, are not included.

7. **The Department has included savings related to the state "Maximum Allowable Cost" model. Why isn't the state MAC budget neutral?**

RESPONSE:

Historically, a State Maximum Allowable Cost program is implemented as a cost savings measure because it standardizes the reimbursement rates for multi-source prescription drugs. At least 35 other Medicaid state agencies have realized significant savings through the adoption of their own methodologies for establishing State Maximum Allowable Cost programs. A State Maximum Allowable Cost program is not intended to be a budget neutral action.

[1] Budget actions that directly affected provider reimbursement included BA-33, "Provider Volume and Rate Reductions," January 23, 2009; ES-2, "Medicaid Program Reductions, August 24, 2009; and, ES-6, "Medicaid Provider Rate Reductions," December 1, 2009

Currently, reimbursement for prescription drugs by Colorado Medicaid is the lowest rate as determined by four methodologies: Federal Upper Limit, Average Wholesale Price, Direct Price, and Usual and Customary Charge. In FY 2009-10 the Department is working to establish a State Maximum Allowable Cost program which will become an additional methodology available to the Department for the determination of reimbursement rates on pharmacy claims.

The Federal Upper Limit, Average Wholesale Price and Direct Price are national indexes, whereas Colorado Medicaid's State Maximum Allowable Cost program will be created to more closely reflect the market conditions unique to Colorado pharmacies. The State Maximum Allowable Cost program will establish a reimbursement rate for multi-source prescription drugs that are of the same chemical content, dosage, and form based upon data provided by local pharmacies.

The use of a variety of reimbursement methodologies assures the Department that pharmacies are reimbursed at a fair price based on various data sources while at the same time making sure that the Department is a prudent purchaser of prescription drugs.

Home Health Rates & Home and Community-Based Services

8. **Please describe the total impact to home health reimbursement and home and community based services from the provider rate reductions and benefit changes.**

RESPONSE:

The Department held nine public forums from late January through mid-June, 2009 specifically targeted to sharing ideas and seeking input from clients, advocates, providers and other stakeholders on home health and Home and Community-Based Services (HCBS) expenditure reductions. Not all ideas proposed by stakeholders were incorporated, but the implemented rate reductions reflect the discussions and options identified as a result of this input.

In July, Certified Nurses Aide (CNA), Personal Care, and Homemaker were specifically exempted from any rate reduction in recognition of the importance of these services in assisting long-term care clients to remain in community settings. Therapies, skilled nursing, and other HCBS services received a 2% cut in July. All HCBS and Home Health services received an across-the-board cut of 1.5% in September and 1% in December.

The cumulative effect of the cuts thus far is a 2.5% cut to CNA, Homemaker, and Personal Care, and a 4.4% cut to Nursing, Therapies, and other skilled care. These reimbursement reductions are estimated to result in $8,445,936 in savings for HCBS services and $4,826,932 in savings for Home Health services.

9. **Please provide a description of a home health visit. Will reducing payment to ½ hour increments adequately reimburse providers for the service? Is there a policy rationale for this reduction besides budget savings? How will reducing home health rates affect rural home health providers?**

RESPONSE:

Description of Home Health service

Home health services refer to health and medical services provided in the individual client's home under a physician's order and may include wound care, in-home infusion services, nursing services, therapies (occupational, physical and speech), medication administration and skilled assistance with activities of daily living. The proposed change in reimbursement methodology only impacts the skilled nursing home visits and does not affect any skilled assistance with activities of daily living provided by Certified Nurses Aides (CNA). A skilled nursing home health visit typically includes a "head-to-toe" assessment observation by a nurse (RN or LPN), skilled nursing tasks in accordance with the client's care plan, medical documentation of the observation and tasks completion, identification of additional care needs, and tracking of progress in meeting care goals. If CNA services are part of the care plan, nurse supervisory visits are required.

Background

Data available to the Department from oversight surveys and OASIS (Outcome and Assessment Information Set) documentation shows that many home health visits are about one hour in length. The Department's current reimbursement methodology pays for one visit up to 2.5 hours for skilled nursing. While a service billing unit exists for a "brief" nursing visit, most visits are reimbursed using the full 2.5 hour unit.

Adequacy of Reimbursement

The proposed change in units of service for the rate methodology will still pay the current total rate for 2.5 hours of care, if that much time is spent in direct client care. However, should a lesser amount of time be spent in providing direct client care, the reimbursement paid will better reflect the time expended. Actual rates per unit of service are not yet finalized and will reflect considerations of medical record documentation time and rural travel. Several other states do not reimburse separately for medical record documentation or other administrative tasks but reimburse the first unit in a day to a specific client at a higher rate than subsequent units, essentially "front-loading" the initial unit much like Colorado currently pays for Brief Nursing 1st/2nd units and Home Health Aide Basic/Extended units.

Policy Rationale

In responding to the unprecedented state budget constraints, the Department has looked for opportunities to reduce expenditures in ways that did not rely solely on rate reductions. In the case of Home Health and therapies, the Department's goal is to more accurately pay for direct care services delivered. Paying for a 2.5-hour visit does not accurately capture the direct client contact time in the claims system, nor does it allow for accurate analysis of in-home care utilization changes over time.

Effect on Rural Providers

The Department currently pays a state-wide standard rate that provides no urban/rural differential. Most states' Home Health reimbursement methodology does not include a rural differential or travel reimbursement. The Department shares the Committee's concern about unintended consequences to rural Home Health providers and plans to address this concern as part of a larger restructuring of the Home Health rates methodology. The Department believes it can structure the reimbursement to appropriately address rural travel time concerns and achieve the 20% reduction in Home Health expenditures proposed.

10. **Will reducing services or reimbursement for HCBS and Home Health services increase hospital or nursing facility costs?**

    RESPONSE:

    The Department is not reducing services or reimbursement for HCBS or Home Health services. Currently, the Medicaid program has not experienced a decrease in provider enrollment or service access to home-based care through HCBS or Home Health that would result in a shift to more expensive Nursing Facility or Hospital services. The current higher utilization of HCBS and Home Health services are the result of a long history focused on community placement. As a result, Medicaid funded nursing facility bed days have steadily dropped over the last few years. This drop has been accompanied by a vacancy rate for nursing facility beds that is high compared to other states and also compared to Colorado's history. The Department believes that the continued demonstrated success in encouraging home and community-based services, even in the face of opposed market pressure, is likely to continue. The Department will continue monitoring the trends in access to services and the balance of community-based care compared to institutional care.

11. **Is the State increasing rates for hospitals and other expensive types of care and decreasing rates for lower cost types of care? If so, isn't the State likely to increase overall costs by encouraging utilization of the highest cost care?**

    RESPONSE:

    The Department does not believe that rate increases to hospitals and nursing facilities, which are funded through provider fees, will encourage the use of higher cost care. The Department observes a need for rate increases among a variety of provider groups to provide for sustainable provider networks and to provide access to care. Hospitals were one of two provider groups that were able to provide a ready financing source, through a provider fee, to fund that increase. While the Department understands the need for broad provider reimbursement cuts as a budget cutting tool, the intent of the Department is to mitigate, limit, and monitor any utilization decreases, across all provider groups, which may occur as a result.

    Under the Colorado Health Care Affordability Act inpatient hospital rates are increased to the Medicare rate and outpatient hospital rates are increased to 100% of Medicaid costs.

Medicare payments are generally less than payments by private insurers, and the Department assumes that bringing inpatient Medicaid payments up to this level will not encourage utilization other than that needed to provide clients with appropriate access to care. As shown in Attachment Q11, the supply of hospital beds in Colorado is low compared to other states. Given this relatively low supply of hospital beds, it is not clear that hospitals would be able to increase Medicaid utilization inappropriately.

The rate increases for hospitals within the Colorado Health Care Affordability Act are part of broader reform. Because this broader reform has utilization containment as a goal, this should provide a check upon unanticipated utilization increases. Hospital payment reform has several aspects:

- Increase reimbursement to hospitals to reduce cost shifting to the private sector. The Colorado Health Care Affordability Act increases rates paid for inpatient and outpatient care for Medicaid clients as well as rates paid for the Colorado Indigent Care Program. Further under the Colorado Health Care Affordability Act, there is a reduction in the number of uninsured. Fewer uninsured Coloradans leads to lower uncompensated costs due to uninsured patients to hospitals.

- Modernize and reform hospital reimbursements: The Department has two objectives in reforming hospital payments.

    - First, the Department intends to refine its current bundled payments for inpatient services to more accurately reflect provider cost. The Department currently pays hospitals for inpatient services under a bundle, the Centers for Medicare and Medicaid Services' Diagnosis Related Group (DRG) system of reimbursement. The Department is replacing this with the All-Patient Refined DRG system, which better accounts for patient severity by creating bundled payments that more accurately reflect the costs of services for any given hospitalization. By better matching costs to payment, the Department anticipates a reduction of utilization in bundles that are currently overpaid, and improved access to services for those bundles that are currently underpaid.

    - Second, the Department intends to replace its cost-based outpatient payments with a bundled payment mechanism. Payments based upon bundled flat rates provide an incentive for hospitals to provide the most efficient set of services required to meet client need.

- Performance payments. The Colorado Health Care Affordability Act establishes performance payments to hospitals. These performance payments will primarily focus on reducing unnecessary utilization of emergency department services and unnecessary hospital readmissions. In addition, the Department anticipates that these performance payments will include payments based upon patient safety and health outcomes.

Nursing facilities were the other provider group receiving a provider fee-funded rate increase under HB 08-1114. The Department believes these rate increases will not provide for an inappropriate increase in utilization. Colorado has a set of Single Entry Point agencies, which work to place clients in the most appropriate long-term care setting based on assessment of client need. Also, robust networks of home and community-based providers exist that provide an alternative to nursing facility placement. As a result, Medicaid-funded nursing facility bed days have steadily dropped over the last few years, and are forecast to continue to decline.

Impact of DME Reductions to Clients

12. **Over the past few years, the Department worked with DME providers to provide an adequate and safe amount of nutritional supplies. This has led to decreases in benefits over the last few years. What was the rationale to decrease this benefit once again?**

RESPONSE:

As part of the FY 2010-11 Budget Request the Department has proposed restricting oral nutritional coverage for adults age 21 and older who are able to take in needed nutrition in solid form. The proposal includes continued coverage of supplements for all clients who receive nutrition by tube feedings, for adults with inborn errors of metabolism and for adults with a malnourishment condition. This proposal is in line with the Department's efforts to prudently purchase health care services. The Department believes that some liquid oral nutritional products are being provided to adult clients for non-medical reasons.

Over the past two years, the Department has been working closely with key stakeholders, including durable medical equipment and supply providers to improve the Durable Medical Equipment Program. In FY 2008-09 the Department worked with stakeholders to revise the questionnaire for oral and enteral formulas that is required when requesting approval for these products. The improved questionnaire has helped significantly in decreasing complaints regarding delays to provide the services and has increased the efficiency with which the Department's utilization review contractor is able to make review determinations.

These limitations are similar to coverage provided by Medicare and other state Medicaid programs. The Department believes these changes are responsive to the challenge to provide services in a more cost-effective manner, yet still provide adequate coverage to clients requiring supplemental nutritional services.

13. **Medicare rates for DME providers have also been reduced. Will the Medicaid, as well as the Medicare, rate reductions result in fewer suppliers? If so, how will that impact Medicaid client's access to DME equipment or supplies?**

    RESPONSE:

    In tracking enrollment for durable medical equipment (DME) providers, the Department has no evidence that providers have had to discontinue participation in the Medicaid program. The Department worked collaboratively with these providers to develop alternative measures to the across-the-board rate reductions. Providers were able to identify maximum price amounts and volume limitations for certain products that allowed the July rate reduction to be 1.97% rather than 2%. The Department continues to work with this stakeholder group to further identify volume and utilization controls to put into place as an alternative to continued rate reductions.

    Because the Department has not seen a negative impact on provider enrollment and participation by the DME and supply providers since the rate reductions began in July, it does not anticipate that providers will terminate participation with Medicaid in above-average numbers, nor does it believe that client access to services will be at risk due to these reductions.

14. **DME equipment and supplies are essential to the quality of life for our disabled clients. According to information from the industry, this group has seen almost 9.5 percent decrease to the Medicare reimbursement level overall with some codes as high as a 20 percent reduction? Are these providers being disproportionately reduced when compared to other providers?**

    RESPONSE:

    Durable Medical Equipment (DME) providers have two primary means of public reimbursement, Medicare and Medicaid. It is the Department's understanding that the rate reductions Medicare instituted were in lieu of a regional competitive bidding model that Medicare was implementing. Although the industry is experiencing the effects of both Medicare and Medicaid reductions, it is important to note that the Medicaid adjustments were constructed independently of decisions made by Medicare. Although DME vendors are feeling the cumulative effects of both reductions, Medicaid has not disproportionately reduced DME providers when compared to other provider types.

    The Department is committed to continuing to work with the complex rehabilitation providers to decrease the administrative burdens and improve access for clients with disabilities. Removing the need for prior authorization before providing repairs to equipment is an example of a change instituted this past year that both eliminated an administrative burden and improved client access and satisfaction.

Impact to Providers from Delaying Payment

15. **What will be the impact to providers and their business cash flows from reducing Medicaid payments by one month? Specifically address BHO and MCO payment delays for those providers.**

RESPONSE:

The proposed payment delay will be implemented across fee-for-service and managed care providers alike. The delayed payments would result in a $188.1 million reduction to expenditures for FY 2010-11, by pushing expenditures to the first payment cycle in the next fiscal year. Both fee-for-service and managed care providers would manage the effects of a payment delay in a similar manner.

A combination of mechanisms are available to providers and managed care organizations to manage this impact including: delaying payments to their vendors, delaying payroll for their staff, utilizing their organization's cash reserves, or utilizing a line of credit or loan to make payments during the delayed period.

While a payment delay inevitably has an impact on providers and managed care organizations, the Department believes that the impact of a payment delay is substantially less than that of a permanent rate reduction. The alternative to a payment delay is further rate reductions. For example, the Department estimates that the proposed payment delays in FY 2010-11 would reduce total funds expenditure by $188.1 million. To achieve a similar amount of savings, the Department would be required to reduce rates to all Medicaid providers by 8% to 10%. This rate reduction would be on top of the four rate reductions that have already been either implemented or proposed, which have reduced provider rates by as much as 5.4%.

The following table shows the changes in payment dates which would result from the delayed payment proposal:

BHO/MCO Payments	Current	SB 09-265
MMIS Payment Generated	1st Saturday of Month e.g. 6/5/2010	4th Saturday of Month e.g. 6/26/2010
Financial Cycle 'To Be Paid'	6/11/2010	7/2/2010
Colorado Financial Reporting System Electronic Funds Transfer/Actual Payment Date	6/18/2010	7/9/2010

16. **Please describe any concerns with complying with the ARRA prompt pay provisions.**

RESPONSE:

The Department is currently in compliance with the prompt pay requirements specified in the American Recovery and Reinvestment Act of 2009 (ARRA), and believes that it will remain in compliance under the Department's proposed payment delays of two weeks in FY 2009-10.

Under the ARRA prompt pay requirements (valid through December 2010), the Department must pay "clean" claims from practitioners, inpatient hospitals, and nursing facilities within the following schedule to receive the enhanced federal medical assistance percentage (FMAP) – *see row in italics*:

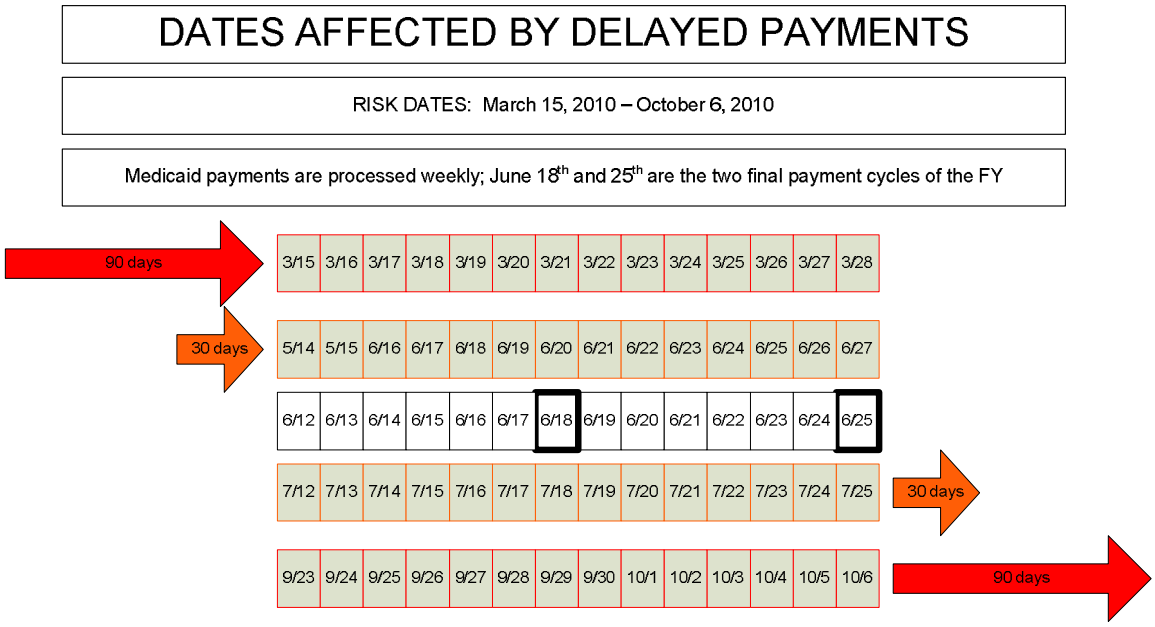
Prompt Pay Requirements	**Source**	**30 days**	**90 days**	**Penalty**
Standard CMS Requirement	42 CFR 447.45 (Practitioner Claims Only)	90%	99%	Non-Financial - Injunctive Relief/CMS Prohibition
Modified ARRA CMS Requirement	*ARRA 5001(f)(2)(A)(i) (Hosp., LTC and Practitioner Claims)*	*90%*	*99%*	*Not eligible for FFP match for ALL claims received the same day ~ 11.59%*

To determine compliance risk, the Department modeled the proposed two-week shift recommendation with FY 2008-09 actual claims data.

The Department reviewed claims from FY 2008-09 to determine its level of compliance under the proposed delay if the payment delay had been in effect. In its review, the Department did not identify any days in that period which would have been out of compliance. Therefore, under the assumption that the last fiscal year will be similar to this fiscal year, the Department anticipates that it would not lose any of the enhanced federal match it receives under ARRA.

However, due to fluctuations in claims submissions and volumes, this is not certain. If the Department is out of compliance for any day during the FY 2009-10 period, the Department would lose the estimated 11.59% of the enhanced federal match for all claims and claim types on the day in which it did not meet the prompt pay requirements. This applies even if all other individual claims were paid within the boundaries, and for all claim types.

In looking at the dates impacted by the FY 2009-10 two-week shift, the Department would need to ensure compliance from March 15, 2010 through October 6, 2010 to avoid the loss of the enhanced federal match due to the payment shift. The dates impacted are shown below:



The risk of losing enhanced funding increases when additional weeks are added. However, the ARRA enhanced match expires December 2010, so the Department's recommendations would keep it in compliance (summarized payments below by fiscal year) for a shift in FY 2010-11.

FY 2009-10	52-2=50 weeks worth of payment
FY 2010-11	52+2=54-4=50
FY 2011-12	52+4=56-3=53
FY 2012-13	52+3=55-2=53
FY 2013-14	52+2=54-1=53
FY 2014-15	52+1=53

The Department's proposal to delay four weeks in FY 2010-11 and additional delays depicted in the chart above would occur after the expiration of the ARRA federal medical assistance percentage (FMAP) provisions. If Congress passes an extension to the ARRA FMAP increase, the Department does not believe that the current proposal delaying payment by four weeks would allow it to remain in compliance with the prompt pay provisions in FY 2010-11. However, with ARRA extension additional federal monies would available to mitigate and address this risk.

Other Medicaid Program Reduction

17. **Do private health plans currently reimburse less to mid-level providers than to physicians for the same procedure or office visit?**

    RESPONSE:

    The Department does not have access to private insurance contracts. Data are available on other state Medicaid payment policies and a summary is provided below.

    Mid-level practitioners include Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists and Certified Nurse Midwives. The Department has conducted research to determine the practices of private health plans. There is no single resource to identify private health plan reimbursement practices. Those plans for which the Department was able to locate public information indicated that a variety of approaches were used.

    Some of the specific approaches identified include:

    - Blue Cross/Blue Shield reimburses Certified Registered Nurse Anesthetists 15% less than anesthesiologists.
    - United Health Plan requires physician supervision for these practitioners and reimburses mid-level practitioners at the physician rate.
    - Many private health plans negotiate higher rates for independent mid-level practitioners who practice in rural areas, while paying the independent urban mid-level practitioners at a lower rate than the physician rate.

    As a result of the economic downturn, commercial payers are looking to different reimbursement strategies to manage their costs. The Department found commercial plans paying mid-level practitioners less than physicians but not across all types of mid-level providers or with any consistent pattern.

Based on 2008 data from the Kaiser Family Foundation website, other state Medicaid programs' reimbursement for advanced nurse practitioners include:

	Mid-Level Practitioner Services		
	Certified Registered Nurse Anesthetist	**Nurse Midwife**	**Nurse Practitioner**
Rates Below 90% of Physician Rates	AL, AR, FL, GA, ID, IN, IA, KY, ME, ND	AL, AK, AR, CA, FL, GA, ID, KY, NJ, ND, WY	AL, AK, AR, FL, ID, IN, KS, KY, LA, ND, SC, WY
Rates at 90% of Physician Rates	MS, NC, SC	AZ, MS, MT, WI	AZ, CT, GA, MS, MT, NM, SD
Rates Exceed 90% of Physician Rates	AZ, CA, CO, DE, IL, KS, LA, MD, MN, MO, MT, NE, NV, NM, OH, OK, OR, SD, TX, UT, WA, WV, WI, WY	CO, CT, DE, HI, IL, IN, IA, KS, LA, ME, MD, MA, MI, MN, MO, NE, NV, NH, NM, NY, NC, OH, OK, OR, PA, RI, SC, TX, VT, VA, WA, WV	CO, DE, HI, IL, IA, ME, MD, MA, MI, MN, MO, NE, NV, NH, NJ, NY, NC, OH, OK, OR, PA, RI, TX, VT, VA, WV, WI

18. **Please describe how the nursing facility fee will change under the Department's proposal. Please describe the total impact to nursing facilities under the Department's budget request.**

RESPONSE:

The Department is requesting a 1.5% reduction in nursing facility rates effective March 2010, and a 1.0% reduction in nursing facility rates effective July 2010 as part of the current budget request. The Department believes that both reductions will require a statute change. The Department is working with nursing facility stakeholder groups to develop the legislative framework, including whether the reductions will be offset through an increase to the per-diem provider fee, although such an increase in the fee is not explicitly part of the Department's proposal. For example, as shown in Attachment Q18, if the March 2010 rate reduction is paid with provider fee, it would raise the fee to $6.11. If the reduction is not paid with provider fee, the fee would be $5.75.

The other component of the Department's request includes keeping the General Fund growth component at 0% for FY 2010-11. Attachment Q18 shows the results of the models with and without extended federal medical assistance percentage relief, and before and after SB 09-263 provider fee cap of $7.50.

19. **Please comment generally on Department's policy approach to reducing the Medicaid program in order meet the budget reduction targets necessary because of the economic situation.**

RESPONSE:

The Department is committed to providing accessible, cost-effective, outcomes-focused health care to all eligible populations in Colorado, and to that end, has tried to lessen the impacts of the state's current economic circumstances on public health insurance clients and providers alike. The Department has made a concerted effort to implement initiatives and strategies to reduce expenditures while sustaining provider reimbursement rates and participation levels to the extent possible and maintaining a wide variety of preventive and acute care services for its covered populations, including some of the most vulnerable populations in the state. The Department, in its approach to reducing expenditures of the Medicaid program in order to meet the budget reduction targets, has therefore favored implementing targeted cost-savings measures such as utilization/volume containment strategies and efficiency improvements to generate the savings needed in order to avoid direct decreases in reimbursement levels.

To avoid direct decreases, the Department began an unprecedented, widespread provider/stakeholder communication initiative prior to implementation of initial proposed reductions. The Department actively engaged a wide variety of providers, provider organizations and client advocacy groups to communicate the Department's fiscal limitations and legislative mandate to reduce expenditures. In an effort to avoid across-the-board rate reductions, the Department worked with providers and stakeholders to propose and implement cost-savings measures such as utilization/volume containment strategies and efficiency improvements that would generate the savings needed to avoid the rate reductions. Rate reductions for some service categories were lessened or completely offset by implementation of those cost-savings suggestions that were feasible and appropriate. In those areas where no practical alternatives to the rate reduction were identified, the reductions were applied. In a limited number of areas, providers recommended that the Department implement the across-the-board cuts for their services rather than identify service reductions. Throughout this process, provider organizations and advocacy groups expressed their gratitude for their inclusion in the decision-making process and the collaborative approach taken by the Department. The Colorado Medical Society, specifically, worked closely with the Department throughout this process and expressed its commitment to continue to work with Medicaid in the future. To the extent that additional expenditure reduction measures are needed, the Department would welcome the opportunity to work again with providers and stakeholders to propose cost-savings measures.

Being open and straightforward with providers, clients, and other stakeholders has also been central to the Department's approach. Public notices of all rate changes were published prior to implementation. Fact sheets and contact information were provided on the Department's Web site, as well as summaries of the suggestions received from stakeholders. Department staff attended provider organization meetings to give attendees the opportunity to ask

questions and express ideas and concerns. Stakeholder concerns were addressed by reiterating the Department's commitment to work with stakeholders to identify any possible mechanisms for achieving the legislatively-mandated expenditure reductions. The Department also demonstrated its collaborative approach by making an effort to address non-rate-related concerns raised by stakeholders such as how to streamline administrative processes that affect clients and providers so as to make participation in Medicaid as efficient and administratively uncomplicated as possible.

Noon -1:30 LUNCH

1:30-2:00 DELIVERY OF CARE – ADMINISTRATIVE CARE ORGANIZATIONS

20. **Please describe in detail, the Department's rollout plan for Accountable Care Organizations, specifically the pilot program envisioned for FY 2010-11. Specifically address, what Medicaid populations will be included, how will it be funded, and how will the program's effectiveness and cost savings be determined?**

RESPONSE:

The Accountable Care Collaborative (ACC) was proposed and approved as part of the Department's DI-6, "Medicaid Value-Based Care Coordination Initiative," FY 2009-10 Budget Request, November 3, 2008. The Accountable Care Collaborative focuses on delivering integrated care to clients while maximizing client health and satisfaction. This system of care aligns incentives to promote the health of clients, and ensure high quality, cost-effective, patient-centered and coordinated care for Medicaid clients. Importantly, it also creates aligned incentives for providers to work together to ensure affordability and cost containment. The current model of fee-for-service encourages independent, uncoordinated and volume-based care that neither promotes affordability nor client-centeredness. The ACC reintroduces managed care across the state, but in a model that builds upon the medical home, coordination amongst providers, and a data analytics infrastructure. The model does not envision a return to capitated risk arrangements that proved highly volatile in terms of predictability of rate setting, charging taxpayers a risk premium for transferring insurance risk, decreased transparency, and investing in infrastructure of managed care organizations rather than infrastructure for community care. Like nearly every large corporation that self-insures its employee health plan, the state's Medicaid program with almost 490,000 clients is readily able to self-insure and save taxpayers an unnecessary risk premium. The Department also benefited from a series of Specialty Task Force Meetings convened by the Colorado Medical Society on the reintroduction of managed care into the Medicaid program. The experiences of the Medical Home for Children project showed the Department the value of strengthening primary care and the expanded participation of pediatricians in serving low income children. Furthermore, the state benefited from experiences and results from several states that have adopted non-capitated models of care to manage costs and improve outcomes. Federal health reform also calls for similar models of innovation.

The ACC consists of three layers: primary care providers, Regional Care Coordination Organizations (RCCOs) and one Statewide Data and Analytics vendor. Its rollout will be in stages with the Statewide Data and Analytics Organization being contracted with and operational first; then each of five RCCOs will become operational one at a time, staggered by one month. Below is detailed information regarding the rollout.

Rollout Plan

The Statewide Data and Analytics vendor will be operational in August, 2010. At that time it will begin receiving and testing data from the Medicaid Management Information System.

The RCCOs will have staggered start dates to ensure adequate Department resources for managing the implementations, and to give the RCCOs time to contract with primary care medical providers.

The Department will begin automatic passive enrollment of clients into each one month apart. Enrollment into the first RCCO will begin November 1, 2010. Each RCCO will receive 2,000 clients a month, for 6 months, until they have reached the maximum enrollment of 12,000. Thereafter, enrollment will occur as necessary to maintain census.

All Medicaid client categories and populations are eligible for enrollment:

- Low Income Adults
- Low Income Children
- Disabled Individuals
- Foster care
- Non-Citizens

Importantly, populations in the Department's waiver programs and nursing home residents will be included. This approach builds upon the Medical Home for Children and extends medical homes to all Medicaid clients including complex clients with disabilities. Some categories and populations will not be subject to automated passive enrollment, i.e., dual eligibles.

Funding

Funding for the Accountable Care Collaborative is as described below. The Statewide Data and Analytics Organization will be paid on a fixed price contract basis. The RCCOs will be paid a per member per month case management fee for each member enrolled with that regional entity. Likewise, Primary Care Medical Providers will also be paid a per member per month fee for each member who has selected or been assigned that provider as their primary care physician. These payments reflect additional investments in primary care as well as investments in community-based, coordinated and outcomes-based care.

A portion of the total funding will be withheld from the RCCOs and from the Primary Care Medical Providers to fund a potential incentive payment. When the Department's established goals are met, the withheld funds would be released to the RCCOs and/or Primary Care

Medical Providers as earned. The incentive payments would be paid to the RCCOs and Primary Care Medical Providers on a quarterly basis once the program is established and operating (after the first six months). In addition, the Department is investigating the possibility of sharing a percentage of savings with the RCCOs after health outcomes, quality metrics and budget neutrality have been met. This vehicle gives communities incentives to deliver coordinated care and remove silos that drive avoidable costs and confusion to clients.

Effectiveness and Cost Savings

The program's effectiveness and cost savings will be determined through the application of a number of measurements and standards that will address utilization, health outcomes, and member satisfaction. In addition, the program will be evaluated by an independent third party after its first 18 months of operation.

The Statewide Data and Analytics vendor will establish program and regional baselines for multiple cost and outcomes measures at the beginning of the program. The metrics will include:

- Total costs, net per member per month and incentive fees (to monitor and assure global fiscal savings targets).
- A handful of utilization measures, directly tied to incentive payments, which can provide a closer to real-time quarterly proxy for global savings (e.g., reduction in emergency room utilization, reduction in readmissions, reduction in avoidable imaging and laboratory services, etc.).
- Many health and health outcome metrics, to be derived from stakeholder input and chosen by the RCCOs themselves (e.g., Healthcare Effectiveness Data and Information Set measures, obesity, smoking, suicide, early prenatal care access, blood pressure, birth weight, days between inpatient hospital discharge and the Primary Care Medical Provider follow-up visit, etc.).
- Satisfaction surveys, of Primary Care Medical Providers and enrolled members.
- Disenrollment trends (of members who opt-out of the program). This is another proxy for member satisfaction.
- Primary Care Medical Provider benchmarking, delivered directly to the doctors by secure email, showing how each doctor's assigned members, risk-adjusted, are performing relative to the members of other Primary Care Medical Providers in the same RCCO and across the State.
- Regional profiling, comparing the performance of each RCCO's clients to the clients of other RCCOs.

21. **How will the Department's ACO model build on the State's existing programs, such as Medical Home for Children, Community Health Center's regional initiatives (i.e. Denver Health and Valley Wide), and the EPSDT program?**

22. **How will the ACO model include the State's safety net providers?**

RESPONSE:

The ACC model builds upon the medical home model. The Accountable Care Collaborative takes the medical home for children and applies it to all Medicaid members and then provides client and provider support and accountability through the Regional Care Coordination Organizations (RCCOs). The Medical Home for Children program will continue to operate as it does now and these children will become eligible to receive all of the additional services identified above. Providers of medical home services will have the opportunity for additional case management resources as well as the opportunity to earn bonus incentives for improved performance. The ACC creates additional leverage for medical home providers by creating coordination, resources, and financial incentives for non-medical home providers. The Department oversees 56 provider types and aims to create a system where they are all networked into a common care management infrastructure with aligned outcome and financial incentives. This function is the role of the RCCOs.

<u>Community Health Centers</u>
Community Health Centers are currently, and are expected to remain, central participants for the delivery of services to members enrolled in the Accountable Care Collaborative. The RCCOs will be required to offer contracts to any community health center (and any other primary care provider) in their regions that desire to participate in the program. Community Health Centers that are able to meet the base Medical Home practice requirements, and the Accountable Care Collaborative contractual requirements, will be allowed to participate fully.

In terms of regional initiatives and organizations such as Denver Health and Valley Wide; these organizations are recognized as being potential candidates for the role of RCCO for their respective regions. This possibility is separate and distinct from their roles as key providers of care for a substantial number of Medicaid members in their regions.

<u>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program</u>
Children enrolled in the Accountable Care Collaborative will continue to receive the entire range of EPSDT services that all children receive in Medicaid. The current resources that support the EPSDT program will continue to do so, but they will be augmented by the assistance and expanded support from the RCCOs. These organizations will be required to coordinate with EPSDT providers. EPSDT services do not extend to adults with disabilities or low-income adults. The Department recognizes the need for care management and care coordination for these clients in particular whose complexity demands additional services and whose health are most vulnerable and the costs of non-coordinated care highest.

23. **Why is this model seen as a successful managed care program? Haven't most managed care attempts failed to meet their targeted savings and outcomes for clients? Who ultimately is at risk if the ACO model does not achieve the targeted savings?**

RESPONSE:

Traditional capitated managed care models in the public insurance market have had mixed success in meeting goals of affordability and improving client health outcomes and health status. Traditional managed care has been disadvantaged by incentives that compensate for and encourage volume of services or withholding of care. In addition, traditional managed care has placed too little emphasis on outcomes and the overall health status of the client. There are also only a few examples of capitated managed care for clients with disabilities.

More and more states are looking at how to "manage care" through a non-traditional Primary Care Case Manager or Administrative Services Organization model. The Accountable Care Collaborative builds on a Primary Care Case Manager model that has proven its effectiveness in a number of states. This model emphasizes each client having an established relationship with a primary care physician who provides, directs, coordinates and monitors the client's care. Key to this model is the primary care physician having the necessary infrastructure, resources, and support to coordinate and conduct all of these activities. It is also very important that the primary care physician have the support and participation of the other providers in the community (hospitals, specialists, behavioral health care providers, and other community resources).

The Accountable Care Collaborative model recognizes the importance of these features and provides them by combining two elements that are each considered mandatory for successful delivery of affordable health care and creating accountability for health outcomes and health status. The first is a medical home for each member, which provides the strong primary care structure through which high quality, low cost care will be provided and directed by the primary care provider. The second is the accountable care organization that will support the primary care provider's efforts and manage the full continuum of care across all providers and systems, and be accountable for the overall costs, outcomes and health status of clients.

In this way, the Accountable Care Collaborative combines the best of what has been proven to be successful in cost effectiveness and quality care delivery: the medical home, the accountable care organization focusing on accountability for clients' health, and using electronic information exchange to improve appropriateness of care, timeliness of care, proactive interventions of care, and ultimately care outcomes.

If the Accountable Care Collaborative does not achieve targeted savings, the Regional Care Coordination Organization and the Primary Care Medical Providers will not achieve incentive payments or possible gain-sharing payments (based on cost savings). Ultimately, the State will be at risk as this is a non-risk contract with benefits paid on a fee-for-service basis. This

risk is what currently exists in the fee-for-service system and the ACC will create incentives for transferring the risk.

24. **Please explain specifically why the Telemedicine pilot and the Department's other disease management contracts haven't achieved the desired cost benefits?**

RESPONSE:

Lack of savings in the telemedicine disease management program can to a large degree be attributed to the limited nature of the model. Specifically, the program relied on contractors utilizing remote nurse telephone consultations and tele-monitoring devices. The program was implemented as a pilot program to help the Department evaluate whether this kind of limited intervention could provide value in treating patients with chronic medical conditions, including heart failure, diabetes and chronic obstructive pulmonary disease.

While the Department learned more about the use of remote bio-monitoring technologies, the program was hampered by slow client enrollment, difficulties with vendor data reporting, and lack of awareness by local care givers. The vendor reported savings of $104,000 during the study period of August 2007 to July 2008. But with fully loaded program costs of $448,000 the program lost a total of $344,000.

Rather than continue with this contractor-based model, the Department is implementing a provider-based approach through the Accountable Care Collaborative. This model will provide a more integrated approach, with care being coordinated by the local medical home and regionally-based care coordination organizations. It is hoped that this initiative will provide a superior mechanism for coordinating care across the continuum as well as address co-morbidities typical in high-risk clients served by the Department.

2:00-2:30 MENTAL HEALTH PROGRAM

25. **Please explain how recent rate reductions may impact the actuarial soundness of the mental health capitation rates.**

RESPONSE:

There are two sets of rules that govern 'actuarial soundness' for Colorado Medicaid capitation rates. Federal regulation lists the requirements for determining actuarially sound rates and requires that an actuary retained by the state certify that the rates meet these requirements. Additionally, the federal regulation allows the actuaries to develop a range of appropriate rates, between an upper and lower bound. As a result, any rate within the rate range is actuarially sound, as certified by the Department's actuaries.

In addition, section 25.5-5-404 (1) (l), C.R.S. (2009) requires that a qualified actuary retained by the Behavioral Health Organization (BHO) must certify that the capitation rates are actuarially sound. Therefore, for rates to be actuarially sound, actuaries retained by both the

Department and the BHO must agree that the rate in the contract is actuarially sound. State statute does not require the BHO's actuary to certify the entire rate range developed by the state's actuary. Therefore, when the Department reduces the rate within the actuarially sound rate range through a contract amendment, it opens up a new round of negotiation. Because professional actuarial opinions can vary, the state's existing certification of the range does not guarantee that the BHOs' actuaries will certify the new rate as actuarially sound.

With the planned 2% rate cut, the July 2010 capitated rates will be at 4.5% below the mid-point of the actuarially certified rate range. This is 0.5% above the rate range minimum.

26. **Are service reductions going to be necessary in order for the Behavioral Health Organizations to manage the mental health program under these reduced rates?**

RESPONSE:

The Department has not yet modified its contract to reduce service requirements or otherwise provided a mechanism for Behavioral Health Organizations (BHOs) to reduce services. Rather, the Department assumes that the reductions in rates to date have resulted in the following four reductions in BHOs:

1. BHO gross margins could be reduced or be temporarily negative. However, it is clear that risk contractors cannot permanently operate at a negative margin.
2. BHOs may choose to cut their subcontracted provider rates temporarily, but are constrained, as they need to do so in ways that do not jeopardize contractual network adequacy requirements.
3. BHOs may choose to defer capital expenditures. While this may solve short-term budget shortfalls, delaying certain capital expenditures may result in higher long-term costs.
4. BHOs are working with the Department to determine efficiencies in administrative operations that will not directly impact client care, such as eliminating certain reports, or reducing the frequency of reporting.

While the future rate cuts budgeted for July 1, 2010 will remain within the Department's actuarially sound rate range, it is not yet clear if the above expenditure reductions will be sufficient for the BHOs to absorb the rate cuts and continue to actuarially certify that they can provide services at the current level.

27. **What is the current appropriation for the substance abuse Medicaid benefit, and what is the current utilization of the benefit for the prior fiscal year and the current fiscal year to date?**

RESPONSE:

There is no separate appropriation for the substance abuse treatment benefit. These services are part of the Medical Service Premiums expenditures. The total amount reimbursed for this

benefit in FY 2008-09 was $1,123,170. The total number of unique clients who utilized this benefit in FY 2008-09 was 2,934. For FY 2009-10 (year to date) the amount reimbursed is $518,169 and 1,907 unique clients have utilized this benefit.

28. **Why is the utilization for the substance abuse benefit significantly below the amount allocated for the program? What are the Department's plans, if any, to increase utilization of the benefit? Wouldn't greater treatment of substance abuse result in greater economic benefit to the State?**

RESPONSE:

As stated in the response to question #27, there is not a specific allocation or appropriation for the outpatient substance abuse treatment benefit. Expenditures for the benefit are included in the Medical Services Premium line. Therefore it is not accurate to say that the utilization for the benefit is below the amount allocated for the program. The Department, however, is interested in ensuring that utilization of the benefit is maximized. As a result, the Department monitors the benefit utilization and expenditure data on a quarterly basis.

Since the addition of this benefit in 2006, benefit utilization and overall expenditures have grown consistently. Within the last fiscal year alone the total number of clients served through this benefit has increased from 2,113 to 2,934. The total expenditures have almost doubled from $686,830 in FY 2007-08 to $1,123,170 in FY 2008-09. The attached graph shows the quarterly growth of the program. The Department does not believe that these expenditures tell the whole story. Clients may be receiving substance abuse treatment in other settings including through the Behavioral Health Organization, through their primary care provider, or (for children) through inpatient rehabilitation programs.

In order to ensure continued growth and utilization of the benefit, the Department has been actively working with community stakeholders and staff at the Department of Human Services-Division of Behavioral Health to increase the number of providers enrolled to provide outpatient substance abuse treatment services. One mechanism that will be utilized is to offer enrollment and billing training specifically targeted for these providers. The Department also conducts quarterly meetings with stakeholders to discuss the utilization/expenditure reports and identify potential opportunities for improvement.

The Department does anticipate improved health of clients utilizing the treatment services. It is currently in the process of analyzing the effectiveness of the program in preparation for the program's audit as stated in 25.5-5-313, C.R.S. (2009).

See graph in Attachment Q28.

29. **Does the Department have any plans to have the substance abuse benefit managed by the Behavioral Health Organizations instead of by outpatient providers directly?**

RESPONSE:

The Department does not currently have specific plans to include management of the outpatient substance abuse benefit by the Behavioral Health Organizations. In the 2008 request for proposals, the Department included management of the outpatient substance abuse benefit as an optional service if a request to transfer funding from fee-for-service to the capitation program was pursued by the Department and approved by the Joint Budget Committee. The current contract may remain in effect through the end of FY 2013-14. If the Department chose to pursue inclusion of the outpatient substance abuse benefit in the capitated program during this time, it could do so without reprocuring the contract.

It is important to note that currently, Medicaid clients with co-occurring diagnoses of mental illness and substance use disorder are eligible for the full range of covered mental health services in the managed care program, including integrated treatment for these dual diagnoses. Individuals who have only a substance use disorder may access the outpatient fee-for-service substance abuse benefit.

2:30 – 3:30 IMPLEMENTATION OF HB 09-1293 AND INDIGENT CARE BUDGET REDUCTIONS

30. **Please explain the impacts to hospital reimbursement from all of the different components of the Department's budget request (including reductions to rates, reductions in ICP grant funding, and increases from reimbursement under HB 09-1293).**

RESPONSE:

Colorado Indigent Care Program (CICP) hospital providers were impacted by the elimination of General Fund for CICP payments for private hospitals, the enhanced Rural and Public Hospital CICP provider payments, and the Health Care Services Fund payments. In total funds, these reductions are as follows: for private-owned CICP hospital payments ($26,181,564); for the Rural and Public Hospital payments ($5,000,000); and for the Health Care Services Fund payments ($8,352,000).

The inpatient hospital rate was reduced by 3% on July 1, 2009, then additional reductions of 1.5% and 1.0% were necessary on September 1, 2009 and December 1, 2009 respectively. The outpatient hospital rate was reduced by 1.5% on September 1, 2009 and another 1.2% reduction is planned for January 1, 2010. The outpatient hospital rate is approximately 70% of cost.

The Hospital Provider Fee Oversight and Advisory Board recommended that the Department adjust the Hospital Provider Fee Model to account for the reductions to Medicaid hospital provider rates (inpatient and outpatient) and for the elimination of General Fund for private

CICP hospital payments. These adjustments will help mitigate the impact of the reductions, by allowing hospital provider fee to draw additional federal funds. Federal approval of the hospital provider fee and payments is anticipated by April 2010. Once approved, fees will be collected from and payments will be made to hospitals effective retroactively to July 1, 2009.

31. **Please explain and present in detail the current fee model and reimbursement program for HB 09-1293.**

RESPONSE:

As currently proposed, hospital provider fees are calculated on inpatient and outpatient hospital services. Hospital payments will be increased for Medicaid and Colorado Indigent Care Program (CICP) inpatient and outpatient hospital services through supplemental inpatient and outpatient Medicaid payments and Disproportionate Share Hospital (DSH) payments under the federal allotment. These supplemental payments include targeted payments to hospitals to ensure access for Medicaid clients in rural and metropolitan areas of the state. Free-standing psychiatric, long term care, and rehabilitation hospitals are exempt from paying the fee. For detailed information about fee, payment calculations, and Hospital Provider Fee Model description please see Attachment Q31.

The Department submitted a request for a waiver of federal broad-based and uniform fee requirements and State Plan Amendments for hospital payment increases to the Centers for Medicare and Medicaid Services (CMS) on September 30, 2009. The fee and payments are currently under review by CMS, and Department and CMS staff are working together both informally and formally during this process. As discussions progress, the Department may need to adjust fee and/or payment methodologies to meet federal requirements.

Federal approval is anticipated prior to April 1, 2010 and rules will be presented to the Medical Services Board for adoption. Subsequently fees will be collected from and payments will be made to hospitals effective retroactively to July 1, 2009. Implementation of two of the health coverage expansions will begin upon CMS approval, with implementation of the additional expansion programs anticipated over the next several years.

As presented to the Hospital Provider Fee Oversight and Advisory Board on Tuesday, December 15, 2009, the estimated provider fee and payments for FY 2009-10 are as follows:

- $339.5 million in hospital provider fees will be collected.
- With federal matching funds leveraged by fee revenue, $589.4 million will be paid to hospitals.
- The Hospital Provider Fee Model is expected to generate $210 million in new federal funds (excluding $94.6 million in federal Disproportionate Share Hospital funding that is already paid to hospitals, but refinanced under the Hospital Provider Fee Model).

- In aggregate, hospital providers will receive a net benefit (fee paid minus funds received) of approximately $87.1 million in new direct reimbursements for serving Medicaid and uninsured clients.
- $60.8 million will be available for health coverage expansions for low-income parents and children expansion populations.
- $7.5 million will be available to pay the Department's administrative expenses.

32. **Please explain the economic benefits of HB 09-1293, including the reduction in the cost-shift.**

    RESPONSE:

    In the latest version of the Hospital Provider Fee Model presented to the Hospital Provider Fee Oversight and Advisory Board, in aggregate hospital providers will receive a net benefit (fee paid minus funds received) of approximately $87.1 million in new direct reimbursements for serving Medicaid and uninsured clients. In FY 2009-10, the Hospital Provider Fee Model is expected to generate $210 million in new federal funds (excluding $94.6 million in federal Disproportionate Share Hospital funding that is already paid to hospitals, but refinanced under the Hospital Provider Fee Model).

    As the provider fee begins to fund the expansion of health care coverage to the uninsured (expected to begin in April 2010) additional federal funds will be generated, which will be paid to hospitals and other medical providers who service this low-income population. Once fully implemented, more than $600 million in new federal funds will be realized annually for these health care expansion populations.

    The implementation of the hospital provider fee will reduce the need for hospital providers to shift uncompensated care costs to private payers, and ultimately employers, in the following ways:

    - **Higher rates for public insurance clients**. By raising the rates paid to hospital providers, the need to shift costs is reduced. The hospital provider fee increases rates paid for inpatient and outpatient care for Medicaid clients as well as rates paid for the Colorado Indigent Care Program.

    - **Reducing the number of uninsured**. Fewer uninsured Coloradans leads to lower uncompensated costs due to uninsured patients to hospitals. In the first year, the hospital provider fee will increase eligibility for parents of Medicaid covered children, Child Health Plan *Plus* (CHP+) and CHP+ prenatal care.

    - **Measurement of cost to payment ratio by payer**. The Hospital Provider Fee Oversight and Advisory Board has authorized a workgroup to indicate exactly what data will be collected by hospitals in order to fulfill the legislative requirement to report the difference between costs and payments for each of Medicare, Medicaid, and private insurance. The

workgroup is planned to convene in Spring 2010 and to complete its work in time for data to be collected for the January 2011 Annual Report.

33. **How is the Department addressing the long-term budget concerns in the Department to ensure that funding is available for the lowest and neediest clients first before expanding services and eligibility to higher and non-traditionally served clients?**

RESPONSE:

Through the Colorado Health Care Affordability Act, the Department is expanding eligibility to the neediest and lowest income clients in the State, and these populations are prioritized first. Under the Act, all adults in Colorado up to 100% of the federal poverty level (FPL) will receive health care coverage and eligibility in the Child Health Plan *Plus* (CHP+) will be increased to 250% FPL. For a single adult, 100% FPL is $10,836 annually. For a family of four, 100% FPL is $22,056 and 250% FPL is $55,140. While the income limits for CHP+ are higher than those for Medicaid, the expansion of benefits to Medicaid parents is expected to cover twice as many low-income individuals as the CHP+ expansion.

As demonstrated in the response to question #39, the Department is addressing cost-containment measures and ways to enhance its efforts to optimize the health and functioning of its clients. An increased focus on health status and health outcomes in Colorado's public health insurance programs is an important part of Governor Ritter's Building Blocks to Health Care Reform, designed to contain costs, improve quality and expand the availability of care. The Department's health care initiatives are aimed at not only improving the health outcomes of clients, but to ensure the long-term fiscal stability of the State's Medicaid program.

34. **Please react to staff's proposal to allow HB 09-1293 to fund the deficit in the Health Care Expansion program. How does that impact the model? How does it impact the model if the other expansion population in HB 09-1293 were to receive the higher federal match envisioned under the federal health care reform legislation?**

RESPONSE:

The Department agrees that there is a looming deficit in the Health Care Expansion Fund under current conditions. However, the Department believes that federal health care reform will provide relief to extend the life of the Health Care Expansion Fund and to ensure the fiscal stability of the Department's programs. The Department thinks that it is premature to begin identifying potential funding sources to backfill this deficit before knowing the outcome of health care reform proposals at the federal level. For example, the current proposed Senate bill would increase the enhanced federal match rate for services in the Child Health Plan *Plus* (CHP+) program to 88% in 2013. If this match rate was received in SFY 2010-11, the Department estimates that the state share of CHP+ expenditures would be approximately $52 million lower, about half of which would be Health Care Expansion Fund. The other half of the state funds would be relief to payments from Tobacco Master Settlement Agreement

funds, which have become insufficient to support CHP+ expenditures.

In the coming months as federal reform is finalized and once a federal plan is enacted, the Department will begin scoring the components. After such time, the Executive Branch will draft a multi-year plan that will address the timing of state initiatives and long-term financing issues to be presented to the Joint Budget Committee and the General Assembly.

35. **Please react to the staff's proposal to reinstate in the Health Care Services Fund using the Primary Care Fund moneys in order to draw additional federal matching funds and thereby reduce some of the reduction to ICP clinics. What other comments or thoughts does the Department have that would improve this proposal.**

RESPONSE:

The decision to eliminate the Health Care Services Fund was based on several factors. This time-limited funding source was created using moneys directed through Referendum C in FY 2006-07. Prior to reducing other General Fund moneys, it was determined that reducing moneys generated through Referendum C should occur first. In addition, the funding source expires June 30, 2010. The decision to eliminate the Health Care Services Fund allowed the funding source to expire one year early. The early elimination of this funding source does not eliminate all payments to Colorado Indigent Care Program (CICP) Clinic providers. The appropriation of $6.1 million to reimburse CICP Clinic providers was not impacted.

In FY 2009-10, the Primary Care Fund was reduced through SB 09-271. The Colorado General Assembly reduced the Primary Care Fund allocation by $7.4 million (approximately one quarter of the total appropriation) and allowed the option to reduce the fund up to $15 million total. The current available appropriation is $24,520,000; if the additional reduction is taken, the available funds will be $16,920,000. By reducing the Health Care Services Fund rather than relying on the option to increase the reduction to the Primary Care Fund allows the General Assembly the flexibility to reduce the Primary Care Fund if future revenue forecasts are lower than those available for the November Budget Request. Also, a reduction in the Primary Care Fund to backfill the Health Care Services Fund would only be a temporary measure, since a declaration of a fiscal emergency is necessary to transfer funds out of the Primary Care Fund each year.

In addition, there are more providers who receive the Primary Care Fund than those who serve as CICP clinic providers. Therefore, a reduction in the Primary Care Fund would impact more providers than a reduction in the Health Care Services Fund. In FY 2009-10, 16 clinic providers who do not participate in the CICP will receive funding through the Primary Care Fund. These providers account for 13% of the Primary Care Fund payments this fiscal year.

In September 2009, the Department submitted a State Plan Amendment to eliminate the federal match for the Health Care Services Fund. In recent conversations with the JBC Analyst, the Department stated that CMS had yet to approve that State Plan Amendment.

That information was incorrect, and the Department has now verified with CMS that the State Plan Amendment had been formally approved. Therefore, if funding for the Health Care Services Fund is restored the Department will need to issue a State Plan Amendment to reinstate the federal match. The Department believes that if State Plan Amendments are submitted in January 2010, a CMS approval could be obtained by June 2010 and the federal match restored within FY 2009-10. However, the ability to draw the federal match within FY 2009-10 is dependent upon when the Department is notified that it can submit the State Plan Amendment and CMS' timeline to approve the State Plan Amendment.

The federal match for these payments is generated through a financing mechanism that utilizes the Inpatient Hospital Upper Payment Limit. This limit establishes the maximum amount of federal funds that can be paid to hospitals for inpatient hospital services. The Hospital Provider Fee Model also utilizes the Inpatient Hospital Upper Payment Limit. The Department has allocated room under the Inpatient Hospital Upper Payment Limit to reestablish the federal match for the Health Care Services Fund, without impacting the current payments designed under the Hospital Provider Fee Model. However, if the Health Care Services Fund was permanently eliminated, those federal funds could be utilized to increase hospital payments under the Hospital Provider Fee Model in FY 2010-11.

The Department is supportive of finding a sustainable funding source for CICP Clinic providers, which draws a federal match, but with the implementation of the Hospital Provider Fee Model, utilizing the Inpatient Hospital Upper Payment Limit may not be sustainable in the long run. The Department is currently investigating the ability to increase payments through the Medicaid encounter rate paid to Federal Qualified Health Centers (FQHCs). Almost all CICP clinic providers are FQHCs, with 99% of all CICP clinic provider payments going to a FQHC. Therefore, the Department suggests there is an opportunity to increase the Medicaid encounter rate paid to FQHCs by an equivalent amount that the General Assembly would restore through the Health Care Services Fund that would help offset the losses for providing care to the uninsured and allow for a sustainable funding mechanism, which would not involve complicated statutory changes.

3:30-3:45 BREAK

3:45-4:30 HEALTH CARE REFORM

36. **How would national health care reform, if enacted, impact HB 09-1293 implementation?**

37. **Please give a brief overview the Department's involvement and view of national health care reform as it impacts the Department's programs. What are the benefits and risk to the State from the proposals being discussed before Congress?**

RESPONSE:

As currently written, the Senate bill would set the minimum Medicaid income threshold at 133% FPL effective January 2014, and would change other eligibility requirements such as

calculation of income. The Department is awaiting finalization of federal health care reform to estimate the additional funding needed to comply with new federal Medicaid floor, the change in income calculations, and the federal match rate that the State will receive. As the Colorado Health Care Affordability Act is a partnership with the Colorado Hospital Association (CHA), the Department will have a continuous dialogue with CHA and stakeholders throughout the implementation of both federal reform and the Colorado Health Care Affordability Act to assess the requirements of the model and partnership.

38. **If eligibility is increased, is there any discussion regarding greater cost sharing from the clients.**

    RESPONSE:

    The Department does not at this time know how federal rules around client cost-sharing will change with the national health care reform proposals. If states are afforded more flexibility around cost-sharing than under current federal rules, the Department would consider that option. The Department is demonstrating its openness to such options through its Buy-In Programs for People with Disabilities included in the Colorado Health Care Affordability Act, which would include sliding-scale premiums and cost-sharing based on family income.

39. **Please give a status update of State health care initiatives, not previously covered, that the Department has been pursuing.**

    RESPONSE:

    As Colorado and the nation continue to struggle with historic economic turmoil, the Department remains committed to transforming Colorado Medicaid and its Child Health Plan *Plus* (CHP+) program in order to better serve Coloradans. More people are turning to public health insurance in the midst of this recession. The number of individuals enrolled in Medicaid and CHP+ is growing by the month. The Department currently covers over 550,000 clients, over 10% of the state's population, and spends over 20% of the state's budget to administer its health insurance programs.

    The central focus of health insurance as well as the health delivery system should be maximizing the health of populations served. Unfortunately, maximizing health is not how payers or delivery systems have been financed, incented or structured. Health insurance has its roots in an insurance model designed to protect against consequences of risk events that has promoted a catastrophic and sickness model of care. The health care delivery system has structured itself to focus on treatment of sickness and reacting to sickness. Insurers largely see themselves as payers of health care services rather than promoters of population health; likewise the delivery system views health promotion and disease prevention as ancillary rather than central elements of their structure.

The Department seeks to develop a novel model of public insurance and to promote health, functioning and self-sufficiency as its core goals. It actively seeks providers, communities, and clients to support and partner in the achievement of this goal.

The Medicaid and CHP+ population is amongst the most vulnerable in society due to poor health indicators and a lack of access to and awareness of preventive care. A significant portion of the Department's budget goes to treating the downstream effects of conditions that are preventable or whose impact could be lessened with earlier intervention. Overall, clients enrolled in Medicaid and CHP+ are often sicker and receive less preventive care than the population at large. Although Medicaid and CHP+ cover many preventive and wellness services, especially for pregnant women and children, more can be done to support risk factor and behavior change counseling and to manage chronic conditions. There are limits to what a clinical visit can accomplish, so it is imperative that the Department also engage in activities and interventions that reach beyond the clinical setting and into community settings where healthy behaviors are shaped. Current Medicaid policies are incenting a focus on acute services, leading to over-utilization of emergency room services, and driving up costs.

As the client base continues to grow, it is even more critical the Department accelerate and enhance its efforts to optimize the health and functioning of its clients. An increased focus on health status and health outcomes in Colorado's public health insurance programs is an important part of Governor Ritter's Building Blocks to Health Care Reform, designed to contain costs, improve quality and expand the availability of care. Over the past year, the Department has spearheaded the initiatives described below that are focused on achieving office efficiencies and preventing future higher-intensity, higher-cost health care needs.

Health Profiles

The Department has developed a series of profiles highlighting the health and health care of Colorado Medicaid and Child Health Plan *Plus* (CHP+) clients. The profiles examine the health status of public health insurance clients by client population. Since the summer of 2009, the Department has created profiles for maternal health, children and nursing home residents. Each provides an overview of health successes and challenges and outlines strategies for improvement. To view the profiles, go to: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1250600332906 .

Prevention and Wellness Initiatives

The Department is developing a long-term strategy to improve the health, functioning and self-sufficiency of its clients. The following areas have been prioritized where the Department can be proactive in improving the health of the clients it serves: tobacco cessation, obesity prevention, depression identification and management, and caries reduction. These areas have been selected for their impact on mortality and morbidity and reflect both behaviors as well as conditions that the Department wishes to prioritize for improvement. These initiatives represent some of the areas most in need of improvement for the Medicaid population. The smoking rate for clients enrolled in Medicaid is almost double that of the

general population. Colorado youth lead the country in number of depressive episodes within a year. The obesity rate in low income children is three times the state's rate.

Various prevention and wellness interventions have been identified for implementation over the next few years. Each emphasizes Department partnership with other state and federal agencies, academic institutions, community-based organizations and health care providers. Examples include:

- Identifying Colorado communities with a high number of public insurance clients and stratifying by age and health status to appropriately tailor community-based health interventions.
- Partnering with Baby and Me - Tobacco Free, a program that combines smoking cessation support specific to pregnant women with the incentives of free diapers to help motivate the women to stay smoke free during the first months of the baby's life.
- Promoting 5 Alive!, a collaborative community-wide initiative to provide a supervised wellness program to Colorado 5th graders who have limited access to healthy lifestyle choices for fitness and nutrition.
- Working with the Colorado Behavioral Healthcare Council to survey behavioral health providers on their current health promotion activities and interventions; identify improvement areas; and implement and evaluate needed health promotion and wellness interventions.
- Collaborating with the Colorado Department of Public Health and Environment's Oral Health Unit to recruit and train dental providers and community health coordinators to ensure children have access to dental services.

The Department is in a unique position to impact change because it is now one of the largest purchasers in the state. As the Department moves forward to improve the health conditions of the half million people it serves, it is hopeful that other health plans will come together to enact health-focused care.

Client Employment Support

The Department was recently awarded a Medicaid Infrastructure Grant (MIG) from the Centers for Medicare and Medicaid Services (CMS). This two-year grant begins on January 1, 2010 and provides funding for the Department, in collaboration with the Division of Vocational Rehabilitation and several community-based organizations, to develop a strong infrastructure to support employment and health care coverage for people with disabilities. This effort includes development of a Medicaid Buy-In program for working adults with disabilities. The grant will support helping individuals remain eligible for Medicaid while continuing to work at higher paying jobs; this in turn promotes economic self-sufficiency, independence, overall well-being and mental health, and increases life satisfaction for this population.

Balanced Scorecard

The Department's Medical and CHP+ Administration Office (MCPAO) has instituted a Balanced Scorecard process to measure progress toward achieving the Department's mission of improving access to quality, cost-effective health care for Coloradans. The Balanced Scorecard Institute defines a Balanced Scorecard as "… a strategic planning and management system to align business activities to the vision and strategy of the organization, improve internal and external communications, and monitor organization performance against strategic goals." Balanced Scorecards are composed of domains, or categories, that are related to the organization's mission and MCPAO has selected the following domains:

- Health Outcomes and Quality – relates to clients' health status and the care and services clients receive.
- Satisfaction – relates to satisfaction of clients, providers, stakeholders, state executives and legislators, CMS and co-workers.
- Affordability – relates to the efficiency with which care and services are delivered to Medicaid clients.
- Access – relates to clients' acquisition of care and services.

The concept behind the word "Balanced" is that in order to be effective, all domains need to be considered equally important. Each MCPAO division and section has goals specific to the Department and to their programs. Each staff member has at least one individual performance objective that is a Balanced Scorecard metric. This enables each staff member to know how their work contributes to the Department's mission and to track their progress. For example, goals for the Nursing Facilities Section include:

- The number of Medicaid nursing facility residents who are pain-free equal or exceed the national 90th percentile.
- The number of Medicaid nursing facility residents who experience an emergency room visit are equal to or less than the national average.
- 100% of Hospital Back-Up providers will be satisfied with the program.

Emergency Room Visit Reduction

In FY 2008-09, 885 per 1,000 clients visited an emergency room. This past year the Department convened a multi-disciplinary team of staff and providers to determine ways to decrease unnecessary emergency room (ER) utilization. The Department administered a client survey to learn why clients use the ER for non-emergent conditions. The top five reasons given include: didn't know what else to do, illness seemed serious, ER is open all the time, ER is close to home, and ER care is fast. Plans to increase use of the nurse advice line are underway and include adding the phone number to client medical cards and sending letters to high ER-utilizing clients encouraging use of the primary care office and nurse advice line. The team is also evaluating the feasibility of implementing co-pays for ER visits.

Additionally, the Department is partnering with Valley Wide Health Centers in Alamosa and Peak Vista Community Health Center in Colorado Springs on a federal grant initiative to reduce ER visits.

Alamosa Interim Results:

- 300 people with non-emergent conditions have been deferred from the emergency room to a Valley-Wide Health Systems clinic in one year.
- Approximately 12,000 additional people voluntarily chose to make appointments at the clinic without going to the emergency room.

Colorado Springs Interim Results:

- Over 7,000 people visiting the emergency room at Memorial Health Systems were educated about the availability of primary care.
- 2,000 people made and kept clinic appointments. Over 300 children received immunizations and over 150 diabetics got routine testing as a result.

Contract Performance

In an effort to hold vendors and other agencies more accountable for outcomes, the Department plans to add retainage and withhold provisions to at least 70% of its contracts and interagency agreements this fiscal year.

Center for Improving Value in Health Care

The Center for Improving Value in Health Care (CIVHC) is a public/private coalition of consumers, business leaders, health care providers, insurance companies and state agencies created to identify and implement strategies to improve health care quality and contain costs. It was established by Executive Order D 005 08 signed by Governor Ritter on February 13, 2008 and is a part of the governor's Building Blocks to Health Care Reform plan.

In December of 2008 recommendations defining the governance structure, funding and scope of CIVHC were presented to Governor Ritter. These recommendations are currently guiding the efforts of CIVHC. In April, 2009 CIVHC's first Advisory Board was named and they have been meeting regularly since June 2009. Phil Kalin, former CEO of Rose Medical and a long-time business executive was named CIVHC's first full-time Director in late September 2009.

The primary goals of CIVHC are to develop and implement strategic initiatives that will improve the health of Coloradans, contain costs and ensure better value for health care received. Currently, CIVHC staff and the Board are working on initiatives focused on payment reform, changes in the delivery system and expanding the transparency and availability of cost and quality data. In that regard, one of CIVHC's first projects is to lead the effort for developing an All Payer Claims Database which would provide cost and quality data for consumers, businesses, providers and policy makers.

CHP *Plus*

FY 2008-09 brought significant changes to Child Health Plan *Plus* (CHP+). On February 4, 2009, President Obama signed the Children's Health Insurance Reauthorization Act (CHIPRA), which reauthorized Children's Health Insurance Programs through 2013. In addition to the reauthorization of federal fiscal support, CHIPRA allows states additional flexibility to cover more children. For instance, CHIPRA offers states the option to lift the five-year waiting period for Medicaid and CHP+ eligibility imposed on immigrants. As a result, the Colorado legislature was able to pass HB 09-1353, which authorizes Medicaid and CHP+ to cover legal immigrants when funding becomes available. In addition, the Colorado Health Care Affordability Act (HB 09-1293), designed to cover 100,000 uninsured Coloradans, was passed in April 2009. One of the significant expansions planned by the bill is the increase of income eligibility for CHP+ applicants to 250% of the Federal Poverty Level (FPL). Below are highlights of CHP+ accomplishments in FY 2008-09.

- In FY 2008-09, CHP+ saw an increase of 3,787 children and 95 pregnant women in its average annual enrollments from FY 2007-08.
- To better target the Department's outreach efforts, CHP+ began receiving county specific data from the Colorado Health Institute on eligible but not enrolled populations.
- Key marketing materials and resources were made available in Spanish to facilitate communication between members of the community, agencies and community sites to familiarize the families they served with CHP+. Bilingual fact sheets, brochures, posters and applications; a desk guide and monthly electronic newsletter for professionals; and articles in English and Spanish including key messages regarding CHP+ offered pertinent contact information for families to learn more about CHP+, and how to apply for enrollment into the program.
- The eligibility system, Colorado Benefits Management System (CBMS), was programmed to set a specific identifier for CHP+ newborns born to mothers on the CHP+ Prenatal program. This identifier allows for the newborn to be guaranteed 12 months of eligibility regardless of a change in circumstance. In addition, this identifier allows for accurate data to be captured for reporting purposes.
- In addition to continuing to measure CHP+ health care performance through the Health Effectiveness Data and Information Set (HEDIS), CHP+ has added a new monitoring process through the Department's Balanced Score Care (BSC) initiative. The BSC is an internal tool measuring program and individual employee efforts to impact positive health outcomes.
- CHP+ improved performance in two key HEDIS measures compared to previous years: the Well-Child Visits in the First 15 Months of Life measure and the Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life measure.

Other Grants

Since July 2007 through December 2009, the Department has pursued numerous grant opportunities to fund activities and receive technical assistance to implement Governor Ritter's "Building Blocks to Health Care Reform" initiatives. To date, the Department has been awarded $50,619,955 in grant funding from local health foundations, national

foundations, as well as the federal government. Of this total, $14,415,961 has been received. Grant funding supported the Colorado Household Survey, community outreach, eligibility modernization, private insurance sector pilots, emergency room diversion pilots, the long-term care partnership program, and CIVHC, among many other activities. In addition, the Department has been the recipient of five grants that provided technical assistance for initiatives that included medical homes, state scorecard measures, and health care reform. The Department was able to significantly advance the implementation of initiatives to improve access, increase efficiencies, and gather needed data to effectively manage programs as a result of the grant opportunities.

Eligibility Modernization

The Department launched Colorado Eligibility Modernization Project (CEMP) in the Spring of 2008 as part of Governor Ritter's "Building Blocks to Health Care Reform." with funding provided through the Long Bill, HB 08-1375. The goals of CEMP include the following:

- Enroll and retain those eligible for public health insurance programs like Medicaid and Child Health Plan Plus (CHP+).
- Implement a variety of self-service options that make it easier for applicants to apply for health care programs.
- Ease workload burden on eligibility workers and increase worker satisfaction.
- Reduce application processing times and provide good customer service.
- Increase administrative efficiencies.
- Reduce administrative costs.
- Leverage existing technology (eliminate reliance on paper).
- Design and implement effective policies.

In the Fall of 2009, the Department released the Eligibility and Enrollment for Medical Assistance Programs (EEMAP) request for proposals. This request for proposals integrated many of the recommendations in the Colorado Eligibility Modernization Report, published by the Department's contractor Public Knowledge LLC, into the CHP+ scope of work. Beginning July 1, 2010, the vendor will be required to improve the overall functioning of the eligibility and enrollment activities by using an Electronic Document Management System (EDMS), Interactive Voice Response technology, as well as workflow process management software and reporting tools. In future years, the vendor will be required to process applications for the expansion populations under the Colorado Health Care Affordability Act.

House Bill 09-1020 (Acree-Spence) regarding expediting reenrollment into Medicaid and the Children's Basic Health Plan was signed into law on May 21, 2009. The bill required the Department to develop a process so that individuals could apply for reenrollment over the telephone or through the internet. The bill complemented and augmented the Department's current efforts to modernize eligibility, including the Colorado Benefits Management System (CBMS) Medical Assistance Project (MAP). Included in MAP was the implementation of Phase I of the Colorado Program Eligibility and Application Kit (PEAK) in October 2009. This online application allows people to check if they might be potentially eligible for medical

assistance programs and allows existing clients to check their benefits. In the Spring of 2010, Phase II of PEAK will allow applicants to apply online for the Family and Children's medical assistance programs and will allow existing clients to report their changes online. Improvements to the front end of CBMS are also planned for implementation in the Fall of 2010. The Intelligent Data Entry (IDE) project will make streamline screens within CBMS, eliminate unnecessary fields in CBMS, and make the data entry and navigation within CBMS easier for the CBMS technicians. Efforts are also ongoing to improve client correspondence within CBMS that includes eliminating unnecessary notices and making the notices easier for clients to understand.

The Department also received a grant from the Colorado Health Foundation to hire a contractor to work with county and other medical assistance sites to improve their business processes to improve the timeliness of application processing and eligibility determinations. This initiative will be launched in January 2010.

In September 2009, Colorado was awarded a five-year, competitive federal grant to support health care expansion efforts. The federal Health Resources and Services Administration (HRSA) awarded $70.9 million in grants to 13 states under the State Health Access Program (SHAP). The HRSA SHAP grant is a new federal opportunity to support state efforts to significantly increase health care coverage as part of a plan for comprehensive health care reform. Colorado received $9.96 million for the first year of the program, the third highest award. Colorado has requested $42.9 million over the five-year period; however, states must reapply each year. Subsequent years of funding are contingent upon meeting performance measures and the availability of federal funding.

Colorado's SHAP proposal, the Colorado Comprehensive Health Access Modernization Program, or CO-CHAMP, includes a variety of projects that will lead to greater access to health care, increase positive health outcomes and reduce cost-shifting.

Colorado Health Care Affordability Act (HB 09-1293) Projects: Several CO-CHAMP projects are linked to the implementation of the Health Care Affordability Act which expands coverage to more than 100,000 uninsured Coloradans over the next five years. HRSA SHAP grant funding will support the following HB 09-1293-related activities and include:

Maximizing Outreach, Retention and Enrollment: The Department will conduct effective outreach and marketing campaigns to inform the expansion populations of the availability of public health insurance programs and assist newly eligible expansion populations with the application process and how to access health care services in appropriate settings. Activities in year one include an outreach needs assessment and the distribution of grants to local community-based organizations for targeted outreach.

Eligibility Modernization: Streamlining the Application Process: With the additional 100,000 Coloradans potentially applying for health care coverage, the Department has identified new strategies to make the eligibility and enrollment process more efficient and cost-effective.

Under this project, the Department plans to create interfaces with other state and federal databases to electronically verify required client documentation. An online application for the expansion populations will be implemented to eliminate the need for applicants to submit paper applications. Year one projects include creating interfaces with the Vital Statistics and the Income and Eligibility Verification System (IEVS).
Benefit and Program Design: The Department will develop potential program designs, including models for premium structures, and cost-sharing provisions for the adults without dependents and the buy-in for individuals with disabilities expansion populations. The Department will hire contractors to conduct an actuarial study and fiscal analysis in the development of possible program models.

Premium Assistance Project: Through federal authority, public health insurance programs for children can help eligible persons pay the premiums required to enroll in their private health insurance plans. The Department will expand its pilot premium assistance program, CHP+ at Work, statewide. The current program design allows for a direct subsidy (not to exceed $100 per eligible child per month) to families who enroll their CHP+ child in the parents' employer-sponsored health insurance plan.

Three-Share Community Projects: A three-share health coverage plan is a basic plan that brings together employers, workers without coverage and outside funding to create a coverage plan for those workers who have no other access to health insurance. HRSA SHAP grant funds will support two three-share community projects.

Pueblo Health Access Program (HAP): HAP is a community-based non-profit organization created to provide high quality, affordable, basic health coverage for the uninsured who work for employers based in Pueblo County. To finance the program, enrolled employers contribute one-third of the premiums, employees contribute another third, and the final third of premium costs is shared by the community. Funds will be used to increase participation in HAP through a robust marketing and advertising plan.

San Luis Valley Health Access Program: The goal of the San Luis Valley Health Access Program is to provide a health coverage program aimed at the working uninsured in employer groups where the median hourly wage is $15 per hour or less and the employer group currently provides no health insurance. Grant funding will be used to initially fund the community share in this pilot program.

Evidence-Based Benefit Design Project: Many states are working to develop new, less expensive, portable benefit packages for small employers and part-time and seasonal workers. With HRSA SHAP funding, the Department and its partners will work with providers, insurers, and consumers to develop an evidence-based tool that can be used to design health benefit packages in private and public insurance products. These products will be offered to a targeted population of uninsured Coloradans through a regional pilot program and could eventually be offered statewide.

Hospital Back Up

- The Department requested and received a reduction to the Medical Services Premiums line of $1,937,867 in FY 2009-10 and $2,971,096 in FY 2010-11 to reflect savings from the expansion of the adult HBU program, rate reform of the adult HBU program and the implementation of a pediatric HBU program (BRI-2 "Medicaid Program Efficiencies: FY 2009-10 Budget Request, November 3, 2008, Tables D.1-D.8).

- Upon learning that the Department was proposing reducing its rates by approximately half, the HBU providers refused to take any more HBU clients and were on the news providing criticism of the Department's new rates. At this time preliminary estimates of the average new rate are greater than those used in the budget request. To date, the HBU providers are not taking any new clients.

- The Department is meeting with stakeholders to develop a methodology that is acceptable to stakeholders and the Department. To this end the Department is examining a variety of methodologies including a per diem reimbursement that uses the Medicaid skilled nursing facility (SNF) rate as the base and 'add-ons' to reimburse for the unique needs of HBU residents. These add-ons would compensate for additional nursing hours and, respiratory therapists. The exact structure of the rate methodology and any associated component 'add-ons' is still under discussion.
- No new HBU providers have materialized with whom the Department would be able to expand the HBU program. The Department had projected that the program would phase in 30 additional clients over the course of FY 2009-10.

- The Department has a prospective pediatric provider that has proposed a large facility in Colorado Springs. The Children's Hospital has expressed concerns with the location. Furthermore, the prospective provider is requesting the Department guarantee a minimum census of 30 clients (the number that were to be phased in as a part of the budget request).

Colorado Long-Term Care Partnership

- Colorado residents who purchase Long-Term Care Partnership insurance are able to have more of their assets protected if they later need the state Medicaid program to help pay for their long-term care.
- Through the Partnership, Coloradans have greater control over how they finance their long-term care while saving the taxpayers money.

Program of All-inclusive Care for the Elderly (PACE)

- In 2009, the Department began its third PACE program, for a total of seven sites, providing services for a total of 1,926 elderly Coloradans. PACE (Program of All-inclusive Care for the Elderly) is a Medicare/Medicaid managed care system that provides health care and support services to persons 55 years of age and older, assisting frail individuals to live in their communities as independently as possible by providing comprehensive services depending on their needs. The following amounts of clients have been served in PACE since 2007:
    - 2007 – 1,481 clients

- 2008 – 1,700 clients
- 2009 – 1,926 clients

Colorado Regional Integrated Care Collaborative

In an effort to address the complexity and high costs associated with fee-for-service Medicaid, Colorado is one of seven states participating in an initiative called "Rethinking Care Program for America's Highest Need, Highest Cost Populations." This program was started in January 2008 by the Center for Health Care Strategies and is known in Colorado as the Colorado Regional Integrated Care Collaborative (CRICC). The goal of the program is to better manage the care and costs of subsets of the highest-need, highest cost beneficiaries. The Department is partnering with the Center for Health Care Strategies, local health plans and providers, consumer organizations and other stakeholders to maximize the potential for CRICC to generate sustainable and replicable models that could ultimately reach thousands of Medicaid's most vulnerable patients.

A contract was implemented between the Department and Colorado Access in April 2008 in the following counties: Adams, Arapahoe, Boulder and Broomfield. Denver County was added in October 2008 and Weld County will be added in FY 2009-10. Per internal Department information, the average total monthly enrollment for the CRICC program in FY 2008-09 was 2,018 clients. Further, contract negotiations between the Department and Kaiser Permanente started a second CRICC program in August 2009 in Jefferson County with an estimated year-end enrollment of approximately 1,200 clients for FY 2009-10.

Program effectiveness will be assessed by comparing measures of health care quality, utilization, and expenditures between the enrolled group and a control group of 500 comparable clients not enrolled in the program. It is expected that the intervention will be implemented for at least a two-year period. Evaluation of the programs will be conducted by MDRC, formerly the Manpower Demonstration Research Corporation. MDRC is a nonprofit, nonpartisan policy research organization with extensive experience in conducting randomized controlled studies of social policy initiatives targeted at low-income populations.

HB 09-1293 Hospital Quality Incentive Payment ad hoc committee

Hospital Quality Incentive Payment (HQIP) is a stakeholder group established to determine measures to be used for quality incentive based payment as required by CRS 25.5-4-402 (3) (a), aka the Colorado Health Care Affordability Act. Simply put, this legislation requires hospitals in Colorado to pay a fee to the state based on number of bed days. Some portion of the total claims paid to hospitals by Medicaid is returned to hospitals in the form of a quality based incentive payment.

The goal of HQIP is to incent hospitals serving Medicaid clients for delivering high quality care that yields positive health outcomes. The Department is working with its partners in the community to develop measures specific to the unique needs of the population served by publically funded health care programs while aligning with the Department's goals of improving health outcomes, increasing access to health care, and containing health care costs.

Representatives from hospital and community partners include: quality improvement professionals, Colorado Foundation for Medical Care, Association of periOperative Registered Nurses, Colorado Medical Society, physicians, representatives from the rural community, patient safety advocates, Mental Health of America, the Colorado Cross Disabilities Coalition, the Colorado Rural Health Center, the Colorado Hospital Association and these hospitals and hospital systems: Health One, Centura Health, Parkview Medical Center, Platte Valley Medical Center, The Children's Hospital, San Luis Valley Regional Medical Center, Denver Health, Exempla, Gunnison Valley Hospital and Medical Center of Aurora.

The group began meeting in August, 2009. The group has agreed upon criteria for measures and domains for measures. In the first year, the final measures will be centered on the following domains: readmissions, emergency room utilization, healthy behaviors, patient safety and maternity care. The group is currently working on measures for readmissions and emergency room utilization. It is likely that the measures established for payment will change over time as data become more readily available and as performance improves in key areas.

The goal is to have established measures for all or most of the domains by the end of January 2010. This will include definition of numerator and denominator of the chosen measures. At that point, discussion of payment methodology, data collection and timeline for payment will begin. The Department hopes to have a rule establishing the measures, payment methodology and payment timeline for review by the Medical Services Board by late spring 2010.

<u>The Colorado Olmstead Plan</u>

Olmstead refers to a 1999 Supreme Court decision that mandates states to ensure supported home and community-based housing options for people at risk for being institutionalized. Affected populations include: people with developmental disabilities, people with physical disabilities, people with persistent mental illness, elders and those with brain injury.

A core Olmstead Planning Team has been assembled to develop the Colorado Olmstead Plan. Members represent a wide variety of communities and interests, including: Atlantis/ADAPT, The Legal Center for People with Disabilities and Older People, Colorado Coalition for the Homeless, Accent on Independence, Colorado Cross Disability Coalition, the Arc of Colorado, Foothills Gateway (a Community Centered Board), the Rainbow Center, Denver Regional Council of Governments, Behavioral Health, Inc., the National Alliance on Mental Illness, Access Behavioral Health, the state long term care ombudsman, the University of Colorado and several other state agencies including: the Department of Public Health and Environment, Department of Transportation, and the Department of Legal Affairs.

Meetings of the core team started in November 2009. The core team is now identifying a problem statement, guiding principles and goals for the plan and priority activities. A completed Olmstead Plan will be given to the Governor in July 2010.

40. **Would any cost savings or efficiencies result from combining the Departments of Health Care Policy and Financing, Public Health and Environment, and Human Services into one Health and Social Services Department?**

RESPONSE:

HB 93-1317 created the Department of Human Services (DHS), Department of Health Care Policy and Financing (HCPF), and Department of Public Health and Environment (DPHE) effective on July 1, 1994. These departments were created from the dissolution of the Department of Institutions, Department of Social Services, and the Department of Health.

While a consolidation of HCPF, DHS and DPHE could be possible, the Executive Branch does not, at this time, think it would be desirable. The Executive Branch has not considered consolidating the three departments, and as such has not done an analysis to determine if cost savings would result from a consolidation such as this. The development of such an analysis would take a significant amount of time and resources. The results of such an analysis might indicate that consolidating the departments would be beneficial, however there are several issues surrounding consolidation that would need to be addressed.

The Executive Branch strongly believes that there is benefit to having the departments separated. First, having one organization that consolidates these three departments would create the largest department in Colorado's state government serving very diverse functions that are under different federal oversight agencies. Administering an agency with this broad array of services, a $6.6 billion annual budget and 6,800 FTE would be very difficult to administer effectively. Two of the three departments already perform a wide range of functions (environmental quality and regulation, disease control, disease prevention, developmental disabilities, mental health, food stamps, child welfare, etc.) and increasing the diversity of functions in one department would make it very difficult to determine priorities of the department for strategic direction.

The departments do not operate in silos. For example, members of HCPF program staff serve on committees to develop programs for DHS programs regarding developmental disabilities, mental health, and drug abuse treatment, as well as DPHE programs such as family planning, nurse home visitor for new mothers and infants up to two years of age, enhanced prenatal care, and long term care review.

In addition, there are inherent conflicts of interest in consolidating the departments. For example, HCPF sets Medicaid policy and determines reimbursement rates for Medicaid Providers. DHS on the other hand acts as a Medicaid provider and receives reimbursement from HCPF. If the departments were combined, they would be "paying themselves" for services provided.

Another example of an inherent conflict is that DHS provides inpatient and long term health care services for patients. The DPHE is responsible for inspecting and licensing health

facilities to ensure proper patient care and safety. If the departments were combined, they would be inspecting their own facilities.

Furthermore, the consolidation of these three departments could logically lead to the DPHE sections being separated, as it might not be ideal to have one large "Health and Human Services and Environment" department with environmental protection and regulation work being included with all of the services for people. The separation of the public health functions and the environmental protection functions into different departments could be detrimental. Currently, the environmental protection specialists at DPHE consult and collaborate with the public health specialists to ensure that recommended changes to environmental laws and regulations are protective of the public health. Conversely, public health specialists consult with the environmental specialists to ensure that their recommendations are protective of the environmental quality as well as human health.

Smaller, specialized agencies are able to adapt more quickly to changing circumstances and environments and provide greater transparency and accessibility to the public.

In summary, there are no analyses from which to conclude if there would be a savings or a cost to consolidation. While the consolidation may be possible, for these three departments in particular, the Executive Branch agrees that consolidation is not desirable.

4:30-5:00 CLOSING COMMENTS

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

Please provide:

41. **Organizational charts for your department, showing divisions and subdivisions (with geographic locations).**

    RESPONSE:

    This information was provided in the Department's November 6, 2009 Budget Request, as described in the OSPB Budget Instructions published on May 29, 2009.

42. **Definitions of the roles and missions of your department, its divisions and subdivisions.**

    RESPONSE:

    This is a part of the Department's Strategic Plan which was submitted in the Department's November 6, 2009 Budget Request, as described in the OSPB Budget Instructions published on May 29, 2009.

43. **The number of current personnel and the number of assigned FTE by division and subdivision (with geographic locations), including all government employees and on-site contractors.**

    RESPONSE:

    The Position and Object Code Detail Report was included in the Department's November 6, 2009 Budget Request as Schedule 14. This is the information that is available on FTE at this time.

44. **A specific list of names, salaries, and positions by division and subdivision of any salaried officer or employee making over $95,000 per year in FY 2009-10.**

    RESPONSE:

    The Department will provide this information as an attachment to its 2009 Hearing Responses, but using position numbers instead of individual employee names. *Please see Attachment Q44.*

45. **A specific list of names, bonuses, and positions by division and subdivision of any salaried officer or employee making over $95,000 per year who received any bonuses in FY 2008-09.**

    RESPONSE:

    No employee received a performance-pay bonus in FY 2008-09.

46. **Numbers and locations of any buildings owned or rented by any division or subdivision (by location) and the annual energy costs of all buildings.**

    RESPONSE:

    The Department will provide this as an attachment to its 2009 Hearing Responses. These will only be buildings funded within the department's budget, and does not include buildings that are at institutions of higher education. *Please see Attachment Q46-Q47.*

47. **Any real property or land owned, managed, or rented by any division or subdivision (by geographic location).**

    RESPONSE:

    The Department will provide this as an attachment to its 2009 Hearing Responses. These will only be property funded within the department's budget, and does not include properties that are at institutions of higher education. *Please see Attachment Q46-Q47.*

48. **List essential computer systems and databases used by the department, its divisions and subdivisions, with their actual FY 2008-09 expenditures.**

RESPONSE:

Please see the Governor's Office of Information Technology for this information.

49. **Any actual FY 2008-09 expenditures over $100,000 total from the department or from its divisions and subdivisions to any private contractor, identifying the contract, the project, and whether the contracts were sole-source or competitive bid.**

RESPONSE:

The Governor has determined that this request is administratively burdensome and is best accessed through the State Controller. Please contact the State Controller for a report with this information.

50. **The amount of actual FY 2008-09 expenditures for any lobbying, public relations, gifts, public advertising, or publications including:**
    a. **expenditures for lobbying by public employees, contract lobbyists, or "think tanks;"**
    b. **expenditures for lobbying purposes at other levels of government;**
    c. **expenditures for lobbying purposes from grants, gifts, scholarships, or tuition;**
    d. **expenditures for publications or media used for lobbying purposes;**
    e. **expenditures for gratuities, tickets, entertainment, receptions or travel for purposes of lobbying elected officials; or**
    f. **Expenditures for any public advertising. Include all advertising campaigns, including those that are not for public relations.**

RESPONSE:

The Governor's Office collected the information outlined in this question and gave it to the Legislative Council Services (LCS) in September 2009. Please contact LCS to request the information.

51. **List of all boards, commissions, and study groups, including actual FY 2008-09 expenditures, travel, per diem budgets and assigned FTEs.**

    RESPONSE:

    The Governor's Office collected that information and gave it to the JBC in August 2009. Please contact OSPB to request a copy of what was sent. The Governor has determined that the remainder of this request is administratively burdensome as the operating budget is not appropriated or expended according to specific FTE.

52. **Suggest budget and staff reductions, including reductions in FTE and hours, by division and subdivision that will reduce your department's total FY 2010-11 General Fund expenditures by 12.5% relative to FY 2009-10 appropriations before any adjustments that have been announced since the end of the 2009 session.**

    RESPONSE:

    Please see the Governor's November 6, 2009 Budget Request for budget balancing proposals for FY 2010-11, and his December 1, 2009 Budget Balancing package for FY 2009-10.

53. **Suggest budget and staff reductions, including reductions in FTE and hours, by division and subdivision that will reduce your department's total FY 2010-11 General Fund expenditures by 25.0% relative to FY 2009-10 appropriations before any adjustments that have been announced since the end of the 2009 session.**

    RESPONSE:

    Please see the Governor's November 6, 2009 Budget Request for budget balancing proposals for FY 2010-11, and his December 1, 2009 Budget Balancing package for FY 2009-10.